# SUSANA MARTINEZ, GOVERNOR



#### RETTA WARD, CABINET SECRETARY

Date: January 5, 2016

To: William Wagner, Executive Director

Provider: Community Options, Inc.

Address: 811 St. Michael Drive, Suite 107 State/Zip: Santa Fe, New Mexico 87505

E-mail Address: bill.wagner@comop.org

CC: Robert Stack, Chief Executive Officer

Address: 16 Farber Road

State/Zip: Princeton, New Jersey 08540

E-Mail Address <a href="mailto:robert.stack@comop.org">robert.stack@comop.org</a>

Region: Northeast

Survey Date: October 19 – 22, 2015

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: 2012: Living Supports (Supported Living, Family Living); Inclusion Supports (Customized

Community Supports)

2007: Community Living (Supported Living) and Community Inclusion (Adult Habilitation)

Survey Type: Routine

Team Leader: Leslie Peterson, BBA, MA, Healthcare Surveyor, Division of Health Improvement/Quality

Management Bureau

Team Members: Anthony Fragua, BFA, Health Program Manager, Division of Health Improvement/Quality

Management Bureau; and Corrina Strain, RN, BSN, Healthcare Surveyor, Division of Health

Improvement/Quality Management Bureau

Dear Mr. Wagner:

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

# **Determination of Compliance:**

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

# Partial Compliance with Conditions of Participation

# **DIVISION OF HEALTH IMPROVEMENT**

5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108 (505) 222-8623 • FAX: (505) 222-8661 • http://www.dhi.health.state.nm.us

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

- Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation
- Tag # 1A22 Personnel Competency
- Tag # 1A28.1 Incident Mgt. System Personnel Training

This determination is based on noncompliance with one or more CMS waiver assurances at the Condition of Participation level as well as Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

#### Plan of Correction:

The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the receipt of this letter.

# **Submission of your Plan of Correction:**

Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. (See attachment "A" for additional guidance in completing the Plan of Correction).

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

- 1. Quality Management Bureau, Attention: Amanda Castaneda, 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

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

## **Billing Deficiencies:**

If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a Void/Adjust claims or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: Julie Ann Hill-Clapp
HSD/OIG
Program Integrity Unit
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Or if using UPS, FedEx, DHL (courier mail) send to physical address at:

Attention: Julie Ann Hill-Clapp HSD/OIG Program Integrity Unit 2025 S. Pacheco Street

#### Santa Fe, New Mexico 87505

Please be advised that there is a one-week lag period for applying payments received by check to Voided/Adjusted claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

## Request for Informal Reconsideration of Findings (IRF):

If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

QMB Deputy Bureau Chief 5301 Central Ave NE Suite #400 Albuquerque, NM 87108 Attention: IRF request

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator Amanda Castaneda at 575-373-5716 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,

Leslie Peterson, BBA, MA

Leslie Peterson, BBA, MA Team Lead/Healthcare Surveyor Division of Health Improvement Quality Management Bureau **Survey Process Employed:** 

**Entrance Conference Date:** October 19, 2015

Present: Community Options, Inc.

William Wagner, Executive Director Katya Mahurin, Business Manager

DOH/DHI/QMB

Leslie Peterson, BBA, MA, Team Lead/Healthcare Surveyor

Anthony Fragua, BFA, Health Program Manager Corrina Strain, RN, BSN, Healthcare Surveyor

Exit Conference Date: October 22, 2015

Present: **Community Options, Inc.** 

William Wagner, Executive Director Katya Mahurin, Business Manager

DOH/DHI/QMB

Leslie Peterson, BBA, MA, Team Lead/Healthcare Surveyor

Anthony Fragua, BFA, Health Program Manager Corrina Strain, RN, BSN, Healthcare Surveyor

**DDSD - Northeast Regional Office** 

David Naranjo, Intellectual Developmental Disabilities Specialist

Angela Pacheco, Northeast Regional Manager

Administrative Locations Visited Number: 1

**Total Sample Size** Number: 10

> 2 - Jackson Class Members 8 - Non-Jackson Class Members

7 - Supported Living

2 - Family Living

1 - Adult Habilitation

7 - Customized Community Supports

**Total Homes Visited** Number: 4 Supported Living Homes Visited Number:

Note: The following Individuals share a SL

residence:

# 5, 7, 10 #3, 4, 8, 9

 Family Living Homes Visited Number: 2

Persons Served Records Reviewed Number: 10

Persons Served Interviewed Number:

Persons Served Observed Number: 2 (1 Individual chose not to be interviewed and 1

Individual was not available during on-site

survey)

QMB Report of Findings - Community Options, Inc. - Northeast Region - October 19 - 22, 2015

Survey Report #: Q.16.2.DDW.D3124.2.RTN.01.15.005

Direct Support Personnel Interviewed Number: 9 (Note: 1 Service Coordinator also performed duties

as Direct Support)

Direct Support Personnel Records Reviewed Number: 20 (Note: 2 additional DSP were interviewed, however

DSP personnel records were not provided. Total DSP

count was 22)

Substitute Care/Respite Personnel

Records Reviewed Number: 1

Service Coordinator Records Reviewed Number: 3 (Note: 1 Service Coordinator also performed duties

as Direct Support)

#### 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
  - o Progress on Identified Outcomes
  - o Healthcare Plans
  - Medication Administration Records
  - Medical Emergency Response Plans
  - Therapy Evaluations and Plans
  - Healthcare Documentation Regarding Appointments and Required Follow-Up
  - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement

DOH - Developmental Disabilities Supports Division

DOH - Office of Internal Audit HSD - Medical Assistance Division MFEAD - NM Attorney General

# Attachment A

## Provider Instructions for Completing the QMB Plan of Correction (POC) Process

#### Introduction:

After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued deficiencies and non-compliance.

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings (Providers who fail to complete a POC within the 45 business days allowed will be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at <a href="mailto:AmandaE.Castaneda@state.nm.us">AmandaE.Castaneda@state.nm.us</a>. Requests for technical assistance must be requested through your Regional DDSD Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

# Instructions for Completing Agency POC:

# Required Content

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

# The Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

- 1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
- 2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
- 3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
- 4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and

- sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
- 5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
- 6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your Plan of Correction:

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc.;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

**Note:** Instruction or in-service of staff alone may not be a sufficient plan of correction. This is a good first step toward correction, but additional steps must be taken to ensure the deficiency is corrected and will not recur.

# **Completion Dates**

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

#### Initial Submission of the Plan of Correction Requirements

- 1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
- 2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at <a href="mailto:AmandaE.Castaneda@state.nm.us">AmandaE.Castaneda@state.nm.us</a> for assistance.
- 3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office
- 4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
  - a. Electronically at AmandaE.Castaneda@state.nm.us (preferred method)
  - b. Fax to 575-528-5019, or
  - c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001
- 5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
- 6. QMB will notify you when your POC has been "approved" or "denied."

- a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
- b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
- c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
- d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
- e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
- 7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

#### **POC Document Submission Requirements**

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

- 1. Your internal documents are due within a <u>maximum</u> of 45 business days of receipt of your Report of Findings.
- 2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).
- 3. All submitted documents <u>must be annotated</u>; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
- 4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
- 5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
- 6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
  - Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
  - Copies of "void and adjust" forms submitted to Xerox State Healthcare, LLC to correct all
    unjustified units identified and submitted for payment during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

#### Attachment B

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

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

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

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

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in three (3) Service Domains.

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

- Qualified Provider
- Plan of Care
- · Health, Welfare and Safety

# **Conditions of Participation (CoPs)**

A CoP is an identified fundamental regulation, standard, or policy with which a provider must be in compliance in order to ensure the health and welfare of individuals served. CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances. A provider must be in compliance with CoPs to participate as a waiver provider.

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP (See the next section for a list of CoPs). The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

# CoPs and Service Domains for Case Management Supports are as follows:

## **Service Domain: Level of Care**

Condition of Participation:

1. **Level of Care**: The Case Manager shall complete all required elements of the Long Term Care Assessment Abstract (LTCAA) to ensure ongoing eligibility for waiver services.

## **Service Domain: Plan of Care**

Condition of Participation:

2. **Individual Service Plan (ISP) Creation and Development**: Each individual shall have an ISP. The ISP shall be developed in accordance with DDSD regulations and standards and is updated at least annually or when warranted by changes in the individual's needs.

Condition of Participation:

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

#### **CoPs and Service Domain for ALL Service Providers is as follows:**

## **Service Domain: Qualified Providers**

Condition of Participation:

4. **Qualified Providers**: Agencies shall ensure support staff has completed criminal background screening and all mandated trainings as required by the DDSD.

#### CoPs and Service Domains for Living Supports and Inclusion Supports are as follows:

#### **Service Domain: Plan of Care**

Condition of Participation:

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

# Service Domain: Health, Welfare and Safety

Condition of Participation:

6. **Individual Health, Safety and Welfare: (Safety)** Individuals have the right to live and work in a safe environment.

Condition of Participation:

6. **Individual Health, Safety and Welfare (Healthcare Oversight)**: The provider shall support individuals to access needed healthcare services in a timely manner. Nursing, healthcare services and healthcare oversight shall be available and provided as needed to address individuals' health, safety and welfare.

#### **QMB** Determinations of Compliance

## Compliance with Conditions of Participation

The QMB determination of *Compliance with Conditions of Participation* indicates that a provider is in compliance with all Conditions of Participation, (CoP). The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation in all relevant Service Domains. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) out of compliance in any of the Service Domains.

# Partial-Compliance with Conditions of Participation

The QMB determination of *Partial-Compliance with Conditions of Participation* indicates that a provider is out of compliance with Conditions of Participation in one (1) to two (2) Service Domains. The agency may have one or more Condition level tags within a Service Domain. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains.

Providers receiving a <u>repeat</u> determination of Partial-Compliance for repeat deficiencies at the level of a Condition in any Service Domain may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

#### Non-Compliance with Conditions of Participation

The QMB determination of *Non-Compliance with Conditions of Participation* indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

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

#### Attachment C

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

#### Introduction:

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

#### Instructions:

- 1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief within 10 business days of receipt of the final Report of Findings.
- 2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: <a href="http://dhi.health.state.nm.us/qmb">http://dhi.health.state.nm.us/qmb</a>
- 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 <a href="mailto:Crystal.Lopez-Beck@state.nm.us">Crystal.Lopez-Beck@state.nm.us</a> for assistance.

# The following limitations apply to the IRF process:

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

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

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

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

Agency: Community Options, Inc. – Northeast Region

Program: Developmental Disabilities Waiver

Service: 2012: Living Supports (Supported Living, Family Living); Inclusion Supports (Customized Community

Supports)

2007: Community Living (Supported Living) and Community Inclusion (Adult Habilitation)

Monitoring Type: Routine Survey

Survey Date: October 19 – 22, 2015

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Service Plans: ISP Im	plementation – Services are delivered in a	accordance with the service plan, including	type,
scope, amount, duration and frequency sp	pecified in the service plan.	· ·	
Tag # 1A08	Standard Level Deficiency		
Agency Case File	·		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 Chapter 5 (CIES) 3. Agency Requirements H. Consumer Records Policy: All Provider	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 8 of 10 individuals.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy.	Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:		
Additional documentation that is required to be maintained at the administrative office includes:  1. Vocational Assessments that are of quality and contain content acceptable to DVR and DDSD;	• ISP budget forms MAD 046  ° Not Current (#4, 5)		
Career Development Plans as incorporated in the ISP: and	<ul> <li>Current Emergency and Personal Identification Information</li> </ul>		
Documentation of evidence that services provided under the DDW are not otherwise available under the Rehabilitation Act of 1973	<ul> <li>Did not contain names and phone numbers of relatives, or guardian or conservator (#7)</li> </ul>	Provider: Enter your ongoing Quality Assurance/Quality	
(DVR).	<ul> <li>ISP Signature Page</li> <li>None Found (#2, 4, 5, 9)</li> </ul>	Improvement processes as it related to this tag number here: →	
Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider	<ul> <li>Not Fully Constituted IDT (No evidence of the Individual's involvement) (#7)</li> </ul>		
agency case files for individuals are required to comply with the DDSD Individual Case File Matrix	• ISP Teaching and Support Strategies		

policy. Additional documentation that is required to be maintained at the administrative office includes:

 Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD.

# Chapter 7 (CIHS) 3. Agency Requirements:

**E. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

#### Chapter 11 (FL) 3. Agency Requirements:

**D. Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 12 (SL) 3. Agency Requirements:

D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

#### Chapter 13 (IMLS) 2. Service Requirements:

- C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items)
- · Emergency contact information;
- · Personal identification;
- ISP budget forms and budget prior authorization;
- ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan (PBSP), Behavior Crisis Intervention Plan

- Individual # 5 TSS not found for the following Action Steps:
- Work/Learn Outcome
  - "... will work ten hours a week as per his VAP."
- Individual #9 TSS not found for the following Action Steps:
- ° Live Outcome:
  - ° "... will research freezers to buy."
- ° Work/Learn Outcome:
- "... will explore volunteering and working in his community."
- ° Fun Outcome:
- "... will organize a movie and popcorn night with his housemates."
- "... will organize fun activities for himself."
- Positive Behavioral Support Plan (#1, 9)
- Behavior Crisis Intervention Plan (#8)
- Speech Therapy Plan (#10)
- Occupational Therapy Plan (#5, 7)
- Physical Therapy Plan (#7)
- Documentation of Guardianship/Power of Attorney (#2)

<ul> <li>(BCIP), or other relevant behavioral plans, Medical Emergency Response Plan (MERP), Healthcare Plan, Comprehensive Aspiration Risk Management Plan (CARMP), and Written Direct Support Instructions (WDSI);</li> <li>Dated and signed evidence that the individual has been informed of agency grievance/complaint procedure at least annually, or upon admission for a short term stay;</li> <li>Copy of Guardianship or Power of Attorney documents as applicable;</li> <li>Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays;</li> <li>Written consent by relevant health decision maker and primary care practitioner for self-administration of medication or assistance with medication from DSP as applicable;</li> <li>Progress notes written by DSP and nurses;</li> <li>Signed secondary freedom of choice form;</li> <li>Transition Plan as applicable for change of provider in past twelve (12) months.</li> </ul>		
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications: A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.		
H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.		

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007

# **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case** File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School: and (7) Case records belong to the individual receiving services and copies shall be provided to the

individual upon request.

(8) The receiving Provider Agency shall be provided at a minimum the following records

whenever an individual changes provider		
agencies:		
(a) Complete file for the past 12 months;		
(b) ISP and quarterly reports from the current		
and prior ISP year; (c) Intake information from original admission		
to services; and		
(d) When applicable, the Individual Transition		
Plan at the time of discharge from Los		
Lunas Hospital and Training School or Ft.		
Stanton Hospital.		
•		
NMAC 8.302.1.17 RECORD KEEPING AND		
<b>DOCUMENTATION REQUIREMENTS:</b> A provider		
must maintain all the records necessary to fully		
disclose the nature, quality, amount and medical		
necessity of services furnished to an eligible		
recipient who is currently receiving or who has received services in the past.		
received services in the past.		
B. Documentation of test results: Results of		
tests and services must be documented, which		
includes results of laboratory and radiology		
procedures or progress following therapy or		
treatment.		

Tag # 1A08.1	Standard Level Deficiency		
Agency Case File - Progress Notes			
	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 4 of 10 Individuals.  Review of the Agency individual case files revealed the following items were not found:  Supported Living Progress Notes/Daily Contact Logs  Individual #8 - None found for 7/2, 27 and 8/5, 19, 2015.  Customized Community Services Notes/Daily Contact Logs  Individual #7 - None found for 8/31/2015.  Individual #8 - None found for 7/27 – 31, 2015.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →  Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Chapter 13 (IMLS) 3. Agency Requirements: 4. Reimbursement A. 1 Provider Agencies must maintain all records necessary to fully disclose the service, quality The documentation of the billable time spent with an individual shall be kept on the written or electronic record		
Chapter 15 (ANS) 4. Reimbursement A. 1Provider Agencies must maintain all records necessary to fully disclose the service, qualityThe documentation of the billable time spent with an individual shall be kept on the written or electronic record		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:		
(3) Progress notes and other service delivery documentation;		

Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	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 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.  Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 9 of 10 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 # 5  • None found regarding: Live Outcome; Action Step: " will follow a visual chart of home maintenance to be completed seasonally" for 7/2015 and 9/2015. Action Step is to be completed 3 times per week.  • According to the Live Outcome; Action Step for " will follow a visual chart of home maintenance to be completed seasonally" is to be completed 3 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2015.  Individual # 7	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →  Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

• None found regarding: Live Outcome/Action play with full participation in their communities. The following principles provide direction and Steps: "... will choose her shirt top" for purpose in planning for individuals with 7/2015 and 8/2015. Action Step is to be developmental disabilities. completed 2 times per week. [05/03/94; 01/15/97; Recompiled 10/31/01] None found regarding: Live Outcome/Action Steps: "... will choose her pants/skirt bottom" for 7/2015 and 8/2015. Action Step is to be completed 2 times per week. Individual # 9 None found regarding: Live Outcome/Action Steps: "... will research freezers to buy" for 7/2015 - 9/2015. Action Step is to be completed 1 time per month. • None found regarding: Fun Outcome/Action Steps: ".... will organize a movie and popcorn night with his housemates" for 7/2015 - 9/2015. Action Step is to be completed 1 time per month. • None found regarding: Fun Outcome/Action Steps: ".... will organize fun activities for himself" for 7/2015 – 9/2015. Action Step is to be completed 1 time per month. Individual #10 • None found regarding: Live Outcome/Action Steps: "... will turn on the vibrating switch" for 8/2015. Action Step is to be completed 1 time per week. None found regarding: Live Outcome/Action Steps: "... will turn off the vibrating switch" for 8/2015. Action Step is to be completed 1 time per week.

 None found regarding: Fun Outcome/Action Steps: "... will build sensory tolerance by

- enjoying smells, tastes and environments and creating new friends" for 8/2015. Action Step is to be completed 1 time per week.
- None found regarding: Fun Outcome/Action Steps: "... will enjoy a drink once a week" for 8/2015. Action Step is to be completed 1 time per week.

# Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

#### Individual # 6

 None found regarding: Live Outcome/Action Step: "... will receive verbal prompts and instructions/modeling on how to complete the tasks of running the washer and dryer without ongoing prompts" for 7/2015 and 8/2015. Action Step is to be completed 1 time per week.

# Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

#### Individual # 2

- None found regarding: Work/Learn Outcome/Action Step: "... will select the day" weekly for 9/2015.
- None found regarding: Work/Learn Outcome/Action Step: "... will try new activities" weekly for 9/2015.

#### Individual #7

None found regarding: Work/Learn
 Outcome/Action Step: "... will volunteer at
 the animal shelter" for 8/2015 and 9/2015.
 Action Step is to be completed 1 time per
 month.

- None found regarding: Fun Outcome/Action Step: "... will choose an activity based on research" for 8/2015. Action Step is to be completed 1 time per month.
- None found regarding: Fun Outcome/Action Step: "... will participate in her selected activity" for 8/2015. Action Step is to be completed 1 time per month.

#### Individual #8

- None found regarding: Work/Learn
   Outcome/Action Step: "... will volunteer in
   the community" for 9/2015. Action Step is to
   be completed 4 6 times per month.
- None found regarding: Fun Outcome/Action Step: "... will rate outing using a system developed by staff" for 9/2015. Action Step is to be completed 1 time per month.

#### Individual #9

None found regarding: Work/Learn
 Outcome/Action Step: "... will explore
 volunteering and working in his community"
 for 7/2015 – 9/2015. Action Step is to be
 completed 1 time a week, up to 10 hours
 per week.

# Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

#### Individual #5

None found regarding: Work/Learn
 Outcome/Action Step: "... will job sample
 possible work environments per his VAP" for
 7/2015 – 9/2015. Action Step is to be
 completed weekly.

None found regarding: Work/Learn
 Outcome; Action Step: "... will work ten
 hours a week as per his VAP" for 7/2015 –
 9/2015. Action Step is to be completed
 weekly.

#### Residential Files Reviewed:

# Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

#### Individual #3

- None found regarding: Live Outcome/Action Step: "... will research a different recipe" for 10/1 – 16, 2015. Action step is to be completed 1 time per week.
- None found regarding: Live Outcome/Action Step: "... will prepare needed ingredients" for 10/1 – 16, 2015. Action step is to be completed 1 time per week.
- None found regarding: Live Outcome/Action Step: "... will prepare items to complete recipe and enjoy" for 10/1 – 16, 2015. Action step is to be completed 1 time per week.
- None found regarding: Fun Outcome/Action Step: "... will choose a restaurant or bar using media or her iPad" for 10/1 – 16, 2015. Action step is to be completed 1 time per week.
- None found regarding: Fun Outcome/Action Step: "... will choose an outing" for 10/1 -16, 2015. Action step is to be completed 1 time per week.

Individual #8

- None found regarding: Health/Other Outcome/Action Step: "... will choose a physical activity" for 10/1 - 16, 2015. Action step is to be completed 1 time per week.
- None found regarding: Health/Other Outcome/Action Step: "...will participate in his chosen activity" for 10/1 - 16, 2015.
   Action step is to be completed 1 time per week.

#### Individual #9

- None found regarding: Live Outcome/Action Step: "... will change sheets on bed" for 10/1 - 16, 2015. Action step is to be completed 1 time per week.
- None found regarding: Live Outcome/Action Step: "... will sweep floor in his room" for 10/1 - 16, 2015. Action step is to be completed 1 time per week.
- None found regarding: Work
   Outcome/Action Step: "... will try new
   activities in the community" for 10/1 16,
   2015. Action step is to be completed 1 time
   per week.
- None found regarding: Work
   Outcome/Action Step: "... will try new
   activities, movies, ball games, throwing
   Frisbees" for 10/1 16, 2015. Action step is
   to be completed 1 time per week.
- None found regarding: Fun Outcome/Action Step: "...will establish a safe route to Wendy's and back home" for 10/1 - 16, 2015. Action step is to be completed 1 time per week.

<ul> <li>None found regarding: Fun Outcome/Action Step: "will walk to Wendy's and back home" for 10/1 - 16, 2015. Action step is to be completed 5 times per week.</li> </ul>	
Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:	
Individual #1 • None found for 10/1 - 21, 2015.	
Individual #6 • None found for 10/1 - 19, 2015.	

Tag # IS11 / 5I11	Standard Level Deficiency		
Reporting Requirements	•		
Inclusion Reports			
Reporting Requirements	Based on record review, the Agency did not complete written status reports as required for 2 of 8 individuals receiving Inclusion Services.  Review of the Agency individual case files revealed the following items were not found, and/or incomplete:  Customized Community Supports Semi-Annual Reports  Individual #1 - None found for 9/2014 – 9/2015. (Term of ISP 9/2014 – 9/2015).  Individual #8 - None found for 8/2014 - 7/2015. (Term of ISP 8/2014 – 7/2015)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →  Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
the following:  1. Semi-annual progress reports to the case manager one hundred ninety (190) calendar days following the date of the annual ISP;			
a. Written updates to the ISP Work/Learn Action Plan annually or as necessary due to change in work goals to the case manager. These updates do not require an IDT meeting unless changes requiring team input need to be made (e.g., adding more			

hours to the Community Integrated Employment budget);		
<ul><li>b. Written annual updates to the ISP work/learn action plan to DDSD;</li><li>2. VAP to the case manager if completed externally to the ISP;</li></ul>		
3. Initial ISP reflecting the Vocational Assessment or the annual ISP with the updated VAP integrated or a copy of an external VAP if one was completed to DDSD;		
4. Quarterly Community Integrated Employment Wage and Hour Reports for individuals employed and in job development to DDSD based on the DDSD fiscal year; and		
Data related to the requirements of the Performance Contract to DDSD quarterly.		
CHAPTER 6 (CCS) 3. Agency Requirements: H. Reporting Requirements: The Customized Community Supports Provider Agency shall submit the following: 1. Semi-annual progress reports one hundred ninety (190) days following the date of the annual ISP, and 14 days prior to the annual IDT meeting:		
Identification of and implementation of a     Meaningful Day definition for each person     served;		
<ul> <li>b. Documentation for each date of service delivery summarizing the following:</li> <li>i.Choice based options offered throughout the day; and</li> </ul>		
ii.Progress toward outcomes using age appropriate strategies specified in each		

individual's action steps in the ISP, and		
associated support plans/WDSI.		
c. Record of personally meaningful community		
inclusion activities; and		
moration delivities, and		
d. Written updates, to the ISP Work/Learn		
Action Plan annually or as necessary due to		
change in work goals. These updates do not		
require an IDT meeting unless changes		
requiring team input need to be made.		
requiring team input need to be made.		
e. Data related to the requirements of the		
Performance Contract to DDSD quarterly.		
r chomiance contract to bbob quarterly.		
Developmental Disabilities (DD) Waiver Service		
Standards effective 4/1/2007		
CHAPTER 5 IV. COMMUNITY INCLUSION		
SERVICES PROVIDER AGENCY		
REQUIREMENTS		
E. Provider Agency Reporting		
Requirements: All Community Inclusion		
Provider Agencies are required to submit written		
quarterly status reports to the individual's Case		
Manager no later than fourteen (14) calendar		
days following the end of each quarter. In		
addition to reporting required by specific		
Community Access, Supported Employment,		
and Adult Habilitation Standards, the quarterly		
reports shall contain the following written		
documentation:		
(1) Identification and implementation of a		
meaningful day definition for each person		
served;		
(2) Documentation summarizing the following:		
(a) Daily choice-based options; and		
(b) Daily progress toward goals using age-		
appropriate strategies specified in each		
individual's action plan in the ISP.		
(3) Significant changes in the individual's		
routine or staffing;		

<ul> <li>(4) Unusual or significant life events;</li> <li>(5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;</li> <li>(6) Record of personally meaningful community inclusion;</li> <li>(7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and</li> <li>(8) Any additional reporting required by DDSD.</li> </ul>		

Tag # LS14 / 6L14	Standard Level Deficiency		
Residential Case File			
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 11 (FL) 3. Agency Requirements C. Residence Case File: The Agency must maintain in the individual's home a complete and current confidential case file for each individual.	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 8 of 9 Individuals receiving Family Living Services and Supported Living Services.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
Residence case files are required to comply with the DDSD Individual Case File Matrix policy.  CHAPTER 12 (SL) 3. Agency Requirements C. Residence Case File: The Agency must	Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:		
maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.	Current Emergency and Personal Identification Information     None Found (#6)     Did not contain Pharmacy Information (#1,	Provider:	
CHAPTER 13 (IMLS) 2. Service Requirements B.1. Documents To Be Maintained In The Home:	Did not contain Health Plan (Insurance)	Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
a. Current Health Passport generated through the e-CHAT section of the Therap website and printed for use in the home in case of disruption in internet access;      Description:	information) (#1)  o Did not contain Names and Phone Numbers of Relatives, or Guardian or		
b. Personal identification;     c. Current ISP with all applicable assessments, teaching and support strategies, and as applicable for the consumer, PBSP, BCIP,	<ul> <li>Conservator Information (#7)</li> <li>Did not contain current address and phone Number. (#4)</li> </ul>		
MERP, health care plans, CARMPs, Written Therapy Support Plans, and any other plans (e.g. PRN Psychotropic Medication Plans) as applicable;	° Did not contain Physician's name and phone number. (#4)		
<ul><li>d. Dated and signed consent to release information forms as applicable;</li><li>e. Current orders from health care practitioners;</li></ul>	Annual ISP (#9)		
f. Documentation and maintenance of accurate medical history in Therap website;     g. Medication Administration Records for the	Individual Specific Training Section of ISP (formerly Addendum B) (#9)		
current month; h. Record of medical and dental appointments for the current year, or during the period of stay for	ISP Teaching and Support Strategies     Individual #3 - TSS not found for the following Action Steps:		

- short term stays, including any treatment provided:
- i. Progress notes written by DSP and nurses;
- j. Documentation and data collection related to ISP implementation;
- k. Medicaid card;
- Salud membership card or Medicare card as applicable; and
- m. A Do Not Resuscitate (DNR) document and/or Advanced Directives as applicable.

#### DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications:

A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.

H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.

#### Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS

A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:

- Live Outcome Statement:
  - "...will research a different recipe to prepare at home."
  - > "...will prepare needed ingredients."
  - "...will prepare items for recipe and enjoy."
- ° Fun Outcome Statement:
  - "...will choose a restaurant or bar using media or her iPad once per week."
  - "...will choose an outing once per week."
- Individual #5 TSS not found for the following Action Steps:
- ° Fun Outcome Statement:
  - "...will identify a time to take a vacation to Carlsbad."
  - "...will help pack for his vacation."
  - "...will go on vacation to Carlsbad."
- Individual #9 TSS not found for the following Action Steps:
- ° Live Outcome Statement:
  - "...will research freezers to buy.
- ° Work/Learn Outcome Statement:
  - "... explore volunteering and working in his community."
- ° Fun Outcome Statement:
  - "... organize a movie and popcorn night with his housemates."

(1) Complete and current ISP and all "... will organize fun activities for supplemental plans specific to the individual; himself (go to Shidoni, train ride to (2) Complete and current Health Assessment ABQ, go to zoo) Tool: (3) Current emergency contact information, which • Positive Behavioral Plan (#1, 4, 5, 8, 9) includes the individual's address, telephone number, names and telephone numbers of • Behavior Crisis Intervention Plan (#4, 5) residential Community Living Support providers, relatives, or quardian or conservator, primary care • Speech Therapy Plan (#8, 9) physician's name(s) and telephone number(s), pharmacy name, address and telephone number Occupational Therapy Plan (#5) and dentist name, address and telephone number, and health plan; Physical Therapy Plan (#7) (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past • Healthcare Passport (#1, 7, 8, 9) month (older notes may be transferred to the agency office); Progress Notes/Daily Contacts Logs: (5) Data collected to document ISP Action Plan Individual #1 - None found for 10/1 - 21, implementation 2015. (6) Progress notes written by direct care staff and Individual #6 - None found for 10/1 - 9, by nurses regarding individual health status and physical conditions including action taken in 2015. response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders: (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual: (b) A transcription of the healthcare practitioners prescription including the brand and generic

name of the medication;

prescribed:

deliverv:

(c) Diagnosis for which the medication is

Times and dates of delivery;

(d) Dosage, frequency and method/route of

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

Tag # LS17 / 6L17 Reporting	Standard Level Deficiency		
Requirements (Community Living	Standard Level Deliciency		
Reports) 7.26.5.17 DEVELOPMENT OF THE	Donad on record review, the Agency did not	Provider:	
	Based on record review, the Agency did not	It	
INDIVIDUAL SERVICE PLAN (ISP) -	complete written status reports for 1 of 9 individuals receiving Living Services.	State your Plan of Correction for the deficiencies cited in this tag here: →	
DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:	individuals receiving Living Services.	deliciencies cited in this tag here. →	
C. Objective quantifiable data reporting progress	Review of the Agency individual case files		
or lack of progress towards stated outcomes,	revealed the following items were not found,		
and action plans shall be maintained in the	and/or incomplete:		
individual's records at each provider agency	and/or incomplete.		
implementing the ISP. Provider agencies shall	Supported Living Semi-Annual Reports:		
use this data to evaluate the effectiveness of	Individual # 8 - None found for 8/2014 -		
services provided. Provider agencies shall	7/2015. (Term of ISP 8/2014 – 7/2015)		
submit to the case manager data reports and	172010. (16/11/01/01/0/2014 - 172010)		
individual progress summaries quarterly, or			
more frequently, as decided by the IDT.			
These reports shall be included in the		Provider:	
individual's case management record, and used		Enter your ongoing Quality Assurance/Quality	
by the team to determine the ongoing		Improvement processes as it related to this tag	
effectiveness of the supports and services being		number here: →	
provided. Determination of effectiveness shall			
result in timely modification of supports and			
services as needed.			
Developmental Disabilities (DD) Waiver Service			
Standards effective 11/1/2012 revised 4/23/2013			
CHAPTER 11 (FL) 3. Agency Requirements:			
E. Living Supports- Family Living Service			
Provider Agency Reporting Requirements:			
1. Semi-Annual Reports: Family Living			
Provider must submit written semi-annual status			
reports to the individual's Case Manager and			
other IDT Members no later than one hundred			
ninety (190) calendar days after the ISP			
effective date. When reports are developed in			
any other language than English, it is the			
responsibility of the provider to translate the			
reports into English. The semi-annual reports			
must contain the following written documentation:			
documentation.			

c. Progress towards desired outcomes in the ISP accomplished during the past six (6) months;		
d. Significant changes in routine or staffing;		
e. Unusual or significant life events, including significant change of health condition;		
f. Data reports as determined by IDT members; and		
g. Signature of the agency staff responsible for preparing the reports.		
CHAPTER 13 (IMLS) 3. Agency Requirements: F. Quality Assurance/Quality Improvement (QA/QI) Program: 4. Intensive Medical Living Services providers shall submit a written semi-annual (non-nursing) status report to the individual's case manager and other IDT members no later than the one hundred ninetieth (190th) day following ISP effective date. These semi-annual status reports shall contain at least the following information:		
a. Status of completion of ISP Action Plans and associated support plans and/or WDSI;		
b. Progress towards desired outcomes;		
c. Significant changes in routine or staffing;		
d. Unusual or significant life events; and		
e. Data reports as determined by the IDT members;		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007		

CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS D. Community Living Service Provider Agency Reporting Requirements: All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation:  (1) Timely completion of relevant activities from ISP Action Plans	
(2) Progress towards desired outcomes in the ISP accomplished during the quarter;	
(3) Significant changes in routine or staffing;	
(4) Unusual or significant life events;	
(5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and	
(6) Data reports as determined by IDT members.	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
		fied providers to assure adherence to waive ovider training is conducted in accordance	
Transportation Training  Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff. Date: March 1, 2007 II. POLICY STATEMENTS:  I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall	Based on interview, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 1 of 22 Direct Support Personnel.  When DSP were asked if they had received transportation training including training on the agency's policies and procedures.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
address at least the following:  1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pretrip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)	the agency's policies and procedures following was reported:  • DSP #210 stated, "No." When asked who transported individuals they stated, "I do."	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
(1) Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training			

program in passenger transportation assistance		
before assisting any resident. The passenger		
transportation assistance program shall be		
comprised of but not limited to the following		
elements: resident assessment, emergency		
procedures, supervised practice in the safe		
operation of equipment, familiarity with state		
regulations governing the transportation of persons		
with disabilities, and a method for determining and		
documenting successful completion of the		
course. The course requirements above are		
examples and may be modified as needed.		
(2) Any employee or agent of a regulated facility		
or agency who drives a motor vehicle provided by		
the facility or agency for use in the transportation of		
clients must complete:		
(a) A state approved training program in		
passenger assistance and		
( <b>b)</b> A state approved training program in the		
operation of a motor vehicle to transport clients of		
a regulated facility or agency. The motor vehicle		
transportation assistance program shall be		
comprised of but not limited to the following		
elements: resident assessment, emergency		
procedures, supervised practice in the safe		
operation of motor vehicles, familiarity with state		
regulations governing the transportation of persons		
with disabilities, maintenance and safety record		
keeping, training on hazardous driving conditions		
and a method for determining and documenting		
successful completion of the course. The course		
requirements above are examples and may be		
modified as needed.		
(c) A valid New Mexico driver's license for the		
type of vehicle being operated consistent with		
State of New Mexico requirements.		
(3) Each regulated facility and agency shall		
establish and enforce written polices (including		
training) and procedures for employees who		
provide assistance to clients with boarding or		
alighting from motor vehicles.		
(4) Each regulated facility and agency shall		
establish and enforce written polices (including		

training and procedures for employees who operate motor vehicles to transport clients.		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy.		
CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;		
CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy		
CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:  A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training		

Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.		
CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:  A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.		
CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;		

Tag # 1A20	Standard Level Deficiency		
Direct Support Personnel Training			
Department of Health (DOH) Developmental	Based on record review, the Agency did not	Provider:	
Disabilities Supports Division (DDSD) Policy -	ensure Orientation and Training requirements	State your Plan of Correction for the	
Policy Title: Training Requirements for Direct	were met for 7 of 20 Direct Support Personnel.	deficiencies cited in this tag here: →	
Service Agency Staff Policy - Eff. March 1, 2007			
- II. POLICY STATEMENTS:	Review of Direct Support Personnel training		
A. Individuals shall receive services from	records found no evidence of the following		
competent and qualified staff.  B. Staff shall complete individual-specific (formerly	required DOH/DDSD trainings and certification		
known as "Addendum B") training requirements in	being completed:		
accordance with the specifications described in the			
individual service plan (ISP) of each individual	<ul> <li>Person-Centered Planning (1-Day) (DSP</li> </ul>		
served.	#214)		
C. Staff shall complete training on DOH-approved			
incident reporting procedures in accordance with 7	• First Aid (DSP #201)		
NMAC 1.13.			
D. Staff providing direct services shall complete	• CPR (DSP #201)	Provider:	
training in universal precautions on an annual	·	Enter your ongoing Quality Assurance/Quality	
basis. The training materials shall meet	Assisting With Medication Delivery (DSP)	Improvement processes as it related to this tag	
Occupational Safety and Health Administration	#214, 219)	number here: →	
(OSHA) requirements.			
E. Staff providing direct services shall maintain	Participatory Communication and Choice		
certification in first aid and CPR. The training	Making (DSP #206)		
materials shall meet OSHA			
requirements/guidelines.  F. Staff who may be exposed to hazardous	Supporting People with Challenging		
chemicals shall complete relevant training in	Behaviors (DSP #203, 218, 219)		
accordance with OSHA requirements.			
G. Staff shall be certified in a DDSD-approved	<ul> <li>Teaching and Support Strategies (DSP #203,</li> </ul>		
behavioral intervention system (e.g., Mandt, CPI)	205)		
before using physical restraint techniques. Staff			
members providing direct services shall maintain	(Note: There were 22 total DSP employed by		
certification in a DDSD-approved behavioral	the agency, yet only 20 DSP personnel files		
intervention system if an individual they support	were provided).		
has a behavioral crisis plan that includes the use of			
physical restraint techniques.			
H. Staff shall complete and maintain certification in			
a DDSD-approved medication course in			
accordance with the DDSD Medication Delivery Policy M-001.			
I. Staff providing direct services shall complete			
safety training within the first thirty (30) days of			
Salety training within the mot thirty (30) days of			

employment and before working alone with an individual receiving service.		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy.		
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CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:  A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training		

Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.		
CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:  A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.		
CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;		

Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced.  Developmental Disabilities (DD) Waiver Service Standards effective 11/12012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Indicusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:  After an analysis of the evidence it has been determined there is a significant potential postation to cocur.  Based on interview, the Agency did not ensure training competencies were met for 4 of 9 Direct Support Personnel.  When DSP were asked if they received training and what outcomes they were responsible for implementing, the following was reported:  DSP #210 stated, "Yes, but I think I missed some." (Individual #8)  DSP #220 stated, "Yes, showers, wear clean clothes, brush teeth." Did not mention current ISP Outcomes; research freezers to buy, organize movie night, or organize fun activities. (Individual #9)	Tag # 1A22	Condition of Participation Level		
Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service Plan (ISP) for each individual service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements 1: All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:  CHAPTER 6 (Individual Fig. 1) including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (Individual Fig. 1) including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (Individual Fig. 1) including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (Individual Fig. 1) including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 7 (Individual Fig. 1) including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 8 (Individual Fig. 1) including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 8 (Individual Fig. 1) including aspects of support plans (healthcare and behavioral) including aspects of support plans (healthcare and behavioral) including a	Agency Personnel Competency	Deficiency		
Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual service.  Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013  CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements in All Community Inclusion Providers must provide staff training in accordance with the DSD policy 7-1003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:  A gency Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual Specific Training as pects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.	Department of Health (DOH) Developmental			
Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced.  Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:  CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:				
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A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced.  Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual ISP, including as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:  training competencies were met for 4 of 9 Direct Support Personnel.  When DSP were asked if they received training on the Individual Service Plan and what outcomes they were responsible for implementing, the following was reported:  • DSP #210 stated, "Yes, but I don't know what exact outcomes I am responsible for in the ISP." (Individual #5)  • DSP #210 stated, "Yes, but I think I missed some." (Individual #8)  • DSP #210 stated, "Yes, but I think I missed some." (Individual #8)  • DSP #209 stated, "Yes, showers, wear clean clothes, brush teeth." Did not mention current ISP Outcomes; research freezers to buy, organize movie night, or organize fun activities. (Individual #9)				
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CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:  Enter your ongoing Quality Improvement processes as it related to this tag number here: →  ISP. "(Individual #5)  DSP #216 stated, "Yes, but I think I missed some." (Individual #8)  DSP #210 stated, "Yes, showers, wear clean clothes, brush teeth." Did not mention current ISP Outcomes; research freezers to buy, organize movie night, or organize fun activities. (Individual #9)				
<ul> <li>G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.</li> <li>DSP #216 stated, "Yes, but I don't know what exact outcomes I am responsible for in the ISP." (Individual #5)</li> <li>DSP #210 stated, "Yes, but I think I missed some." (Individual #8)</li> <li>DSP #209 stated, "Yes, showers, wear clean clothes, brush teeth." Did not mention current ISP Outcomes; research freezers to buy, organize movie night, or organize fun activities. (Individual #9)</li> </ul>		<ul> <li>DSP #210 stated, "No" (Individual #3)</li> </ul>		
Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:  exact outcomes I am responsible for in the ISP." (Individual #5)  ■ DSP #210 stated, "Yes, but I think I missed some." (Individual #8)  ■ DSP #209 stated, "Yes, showers, wear clean clothes, brush teeth." Did not mention current ISP Outcomes; research freezers to buy, organize movie night, or organize fun activities. (Individual #9)				
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Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (CCS) 3. Agency Requirements  F. Meet all training requirements as follows:  • DSP #210 stated, "Yes, but I think I missed some." (Individual #8)  • DSP #209 stated, "Yes, showers, wear clean clothes, brush teeth." Did not mention current ISP Outcomes; research freezers to buy, organize movie night, or organize fun activities. (Individual #9)		ISP." (Individual #5)		
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as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (CCS) 3. Agency Requirements  F. Meet all training requirements as follows:  OSP #209 stated, "Yes, showers, wear clean clothes, brush teeth." Did not mention current ISP Outcomes; research freezers to buy, organize movie night, or organize fun activities. (Individual #9)				
aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.  • DSP #209 stated, "Yes, showers, wear clean clothes, brush teeth." Did not mention current ISP Outcomes; research freezers to buy, organize movie night, or organize fun activities. (Individual #9)		some." (Individual #8)		
behavioral) or WDSI that pertain to the employment environment.  CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:  CHAPTER 6 (CCS) 3. Agency Requirements  CHAPTER 6 (CCS) 3. Agency Requirements  Clothes, brush teeth." Did not mention current ISP Outcomes; research freezers to buy, organize movie night, or organize fun activities. (Individual #9)				
employment environment.  CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:  ISP Outcomes; research freezers to buy, organize movie night, or organize fun activities. (Individual #9)				
CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:		clothes, brush teeth." Did not mention current		
CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:  activities. (Individual #9)	employment environment.			
F. Meet all training requirements as follows:				
4. All O attends at 10 and at 10 and at		activities. (Individual #9)		
T. All Customized Community Supports   • DSP #204 stated "Yes but I don't know				
Doi #204 stated, 163, but I doi! t know		<ul> <li>DSP #204 stated, "Yes, but I don't know</li> </ul>		
	Providers shall provide staff training in	exactly what they are." (Individual #10)		
	accordance with the DDSD Policy T-003:			
When bet were asked it the marriadal had a	Training Requirements for Direct Service			
1 Ositive Benavioral Supports Fiant and it 30,	Agency Staff Policy;			
CHARTER 7 (CIHS) 3. Agency Poquirements what the plan covered, the following was	CHARTER 7 (CIUS) 2 Agonos Poquiromento			
	CHAPTER 7 (CIHS) 3. Agency Requirements	reported:		
	C. Training Requirements: The Provider Agency must report required personnel training			
	status to the DDSD Statewide Training			

Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training.

## CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:

A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and **Documentation for DDSD Training** Requirements.

- DSP #210 stated, "Yes, but I don't know what the plan covers." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #3)
- DSP #210 stated, "I think so yeah, but I don't know what the plan covers." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #8)
- DSP #209 stated, "...have talked about it, but don't know if I was trained. "According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #9)

When DSP were asked if the individual had a Behavioral Crisis Intervention Plan and if so, what the plan covered, the following was reported:

- DSP #210 stated, "Yes, but I don't know what the plan covers." According to the Individual Specific Training Section of the ISP, the individual has Behavioral Crisis Intervention Plan. (Individual #3)
- DSP #210 stated, "Yes, give him space."
   However, according to the Individual Specific
   Training Section of the ISP the individual
   does not require a Positive Behavioral Crisis
   Plan. (Individual #8)

When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:

• DSP #210 stated, "Yes, but I don't know what the plan covers. I haven't gotten to that part."

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B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc), information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

#### CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:

A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

B Individual specific training must be arranged and conducted, including training on the ISP

- According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #3)
- DSP #210 stated, "Yes, but I don't know what the plan covers." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #8)

When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:

- DSP #210 stated, "I think so, but I haven't had a training for that either." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #3)
- DSP #210 stated, "Yes, but I still don't know nothing about that one." However, according to the Individual Specific Training Section of the ISP the Individual does not require an Occupational Therapy Plan. (Individual #8)

When DSP were asked if the Individual had a Physical Therapy Plan and if so, what the plan covered, the following was reported:

- DSP #210 stated, "Yes, but haven't had a training." According to the Individual Specific Training Section of the, the Individual requires a Physical Therapy Plan. (Individual #3)
- DSP #210 stated, "Yes, but I don't know, I get so confused." According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #8)

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Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc), and information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

CHAPTER 13 (IMLS) R. 2. Service
Requirements. Staff Qualifications 2. DSP
Qualifications. E. Complete training
requirements as specified in the DDSD Policy T003: Training Requirements for Direct Service
Agency Staff - effective March 1, 2007. Report
required personnel training status to the DDSD
Statewide Training Database as specified in the
DDSD Policy T-001: Reporting and
Documentation of DDSD Training Requirements
Policy;

When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:

- DSP #210 stated, "I haven't got trained on those either." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Aspiration, Seizures, Constipation, Bowel and Bladder, Skin and Wound. (Individual #3)
- DSP #209 stated, "No." As indicated by the Agency file, the Individual has Health Care Plans for Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Body Mass Index, Status of Care Hygiene, Seizures, Endocrine with Diabetes, A1C Levels, and Pain. (Individual #4)
- DSP #210 stated, "For his Diabetes, that's all I know." As indicated by the Agency file, Osteopenia and as indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Body Mass Index, Aspiration Risk, Seizure disorder, Respiratory, Falls, Pain. (Individual #8)
- DSP #209 stated, "I don't think so." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Status of care Hygiene, Seizure Disorder. (Individual #9)

When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:

- DSP #210 stated, "I don't think she has any of those." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for: Aspiration and Seizure Disorder. (Individual #3)
- DSP #209 stated, "I don't think so." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for: Seizure Disorder, Endocrine with Diabetes, and A1C Levels. (Individual #4)
- DSP #210 stated, "I don't know." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for: Aspiration Risk, Seizure Disorder, Endocrine, Respiratory, Falls, and Pain. (Individual #8)
- DSP #209 stated, "I don't think so." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for: Seizure Disorder. (Individual #9)

### When DSP were asked if the Individual had a Seizure Disorder, the following was reported:

- DSP #210 stated, "He should yes, I believe in his book, but haven't been trained yet." As indicated by the Individual Specific Training section of the ISP (residential) staff are required to receive training on seizures. (Individual #8)
- DSP #209 stated, "I don't think so." As indicated by the Individual Specific Training section of the ISP (residential) staff are

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required to receive training on seizures. (Individual #4)

 DSP #209 stated, "I don't remember if I received training." As indicated by the Individual Specific Training section of the ISP (residential) staff are required to receive training on seizures. (Individual #9)

When DSP were asked if they assisted the individual with medications and had received the Assisting with Medications (AWM) training, the following was reported:

- DSP #210 stated, "I still have some training to do. I'm still getting help." (Individual #3)
- DSP #210 stated, "I still have some training to do. I'm still getting help." (Individual #8)

When DSP were asked what the individual's Diagnosis were, the following was reported:

- DSP #210 stated, "I'm not sure." According to the individual's Medication Administration Record the individual is diagnosed with Brain Injury, Gastroesophageal Reflux Disease and Depression and Allergic Rhinitis. Staff did not discuss the listed diagnosis. (Individual #3)
- DSP #204 searched the residential file for an extended period of time but was unable to answer. According to the individuals Medication Administration Record the individual is diagnosed with Seizures Encephalitis, Depression, Hypothyroidism, Hypertension, Mental Retardation and Osteoarthritis. Staff did not discuss the listed diagnosis. (Individual #7)

• DSP #210 stated, "Diabetic, sugar issues, that's the only thing I know." According to the individual's Medication Administration Record the individual is diagnosed with Leukocytopenia Seizures, Anemia Developmental Delay and Pallister Mosaic Syndrome. Staff did not discuss the listed diagnosis. (Individual #8) • DSP #204 searched the residential file for an extended period of time and did not discuss any diagnosis. According to the individuals Medication Administration Record the individual is diagnosed with Mental Retardation Hypothyroidism, Night Blindness, Depressive Disorder, Gastroesophageal Reflux Disease, and Osteopenia. (Individual #10) When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was reported: • DSP #210 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool the individual is allergic to Lamictal. (Individual #3) • DSP #209 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool the individual is allergic to Aspirin and Phenobarbital. (individual #9)

Tag # 1A26	Standard Level Deficiency		
Consolidated On-line Registry			
Employee Abuse Registry			
NMAC 7.1.12.8 REGISTRY ESTABLISHED;	Based on record review, the Agency did not	Provider:	
PROVIDER INQUIRY REQUIRED: Upon the	maintain documentation in the employee's	State your Plan of Correction for the	
effective date of this rule, the department has	personnel records that evidenced inquiry into the	deficiencies cited in this tag here: →	
established and maintains an accurate and	Employee Abuse Registry prior to employment		
complete electronic registry that contains the	for 2 of 24 Agency Personnel.		
name, date of birth, address, social security			
number, and other appropriate identifying	The following Agency personnel records		
information of all persons who, while employed	contained no evidence of the Employee		
by a provider, have been determined by the	Abuse Registry check being completed:		
department, as a result of an investigation of a			
complaint, to have engaged in a substantiated	Direct Support Personnel (DSP):		
registry-referred incident of abuse, neglect or			
exploitation of a person receiving care or	• #202 – Date of hire 10/05/2011.		
services from a provider. Additions and updates		<b>5</b>	
to the registry shall be posted no later than two	<ul> <li>#209 – Date of hire 6/05/2013.</li> </ul>	Provider:	
(2) business days following receipt. Only		Enter your ongoing Quality Assurance/Quality	
department staff designated by the custodian		Improvement processes as it related to this tag	
may access, maintain and update the data in the		number here: →	
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. <b>Prohibited employment.</b> A provider			
may not employ or contract with an individual to			
be an employee if the individual is listed on the			
registry as having a substantiated registry-			
referred incident of abuse, neglect or			
exploitation of a person receiving care or			
services from a provider.			
D. Documentation of inquiry to registry.			
The provider shall maintain documentation in the			
employee's personnel or employment records			
that evidences the fact that the provider made			
an inquiry to the registry concerning that			
employee prior to employment. Such			

documentation must include evidence, based on		
the response to such inquiry received from the		
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. <b>Documentation for other staff</b> . 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.		
other governmental agency.		
	· ·	

Tag # 1A28.1	Condition of Participation Level		
Incident Mgt. System - Personnel	Deficiency		
Training			
NMAC 7.1.14 ABUSE, NEGLECT,	After an analysis of the evidence it has been	Provider:	
EXPLOITATION, AND DEATH REPORTING,	determined the following there is a significant	State your Plan of Correction for the	
TRAINING AND RELATED REQUIREMENTS	potential for a negative outcome to occur.	deficiencies cited in this tag here: →	
FOR COMMUNITY PROVIDERS			
	Based on record review and interview, the		
NMAC 7.1.14.9 INCIDENT MANAGEMENT	Agency did not ensure Incident Management		
SYSTEM REQUIREMENTS:	Training for 10 of 25 Agency Personnel.		
A. General: All community-based service	Direct Compart Daragement (DCD):		
providers shall establish and maintain an incident	Direct Support Personnel (DSP):		
management system, which emphasizes the principles of prevention and staff involvement.	<ul> <li>Incident Management Training (Abuse, Neglect and Exploitation) (DSP# 201, 214,</li> </ul>		
The community-based service provider shall	215, 216, 218)		
ensure that the incident management system	213, 210, 210)		
policies and procedures requires all employees	Service Coordination Personnel (SC):		
and volunteers to be competently trained to	Incident Management Training (Abuse,	Provider:	
respond to, report, and preserve evidence related	Neglect and Exploitation) (SC #224)	Enter your ongoing Quality Assurance/Quality	
to incidents in a timely and accurate manner.	γ (σ σ π = π,	Improvement processes as it related to this tag	
<b>B. Training curriculum:</b> Prior to an employee or	When Direct Support Personnel were asked	number here: →	
volunteer's initial work with the community-based	what State Agency must be contacted when		
service provider, all employees and volunteers	there is suspected Abuse, Neglect and		
shall be trained on an applicable written training	Exploitation, the following was reported:		
curriculum including incident policies and			
procedures for identification, and timely reporting	DSP #200 stated, "I don't know." Staff was		
of abuse, neglect, exploitation, suspicious injury,	not able to identify the State Agency as		
and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed	Division of Health Improvement.		
at annual, not to exceed 12-month intervals. The	DOD #040 -t-td #0it- O-ti		
training curriculum as set forth in Subsection C of	DSP #210 stated, "Community Options would just call the cops." Staff was not able to		
7.1.14.9 NMAC may include computer-based	identify the State Agency as Division of		
training. Periodic reviews shall include, at a	Health Improvement.		
minimum, review of the written training curriculum	Tioditi improvement.		
and site-specific issues pertaining to the	DSP #213 stated, "I don't know." Staff was		
community-based service provider's facility.	not able to identify the State Agency as		
Training shall be conducted in a language that is	Division of Health Improvement.		
understood by the employee or volunteer.	'		
C. Incident management system training			
curriculum requirements:			<u> </u>

- (1) The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to:
- (a) an overview of the potential risk of abuse, neglect, or exploitation;
- **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form;
- **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths:
- **(d)** specific instructions on how to respond to abuse, neglect, or exploitation;
- **(e)** Emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury.
- (2) All current employees and volunteers shall receive training within 90 days of the effective date of this rule.
- (3) All new employees and volunteers shall receive training prior to providing services to consumers.
- D. Training documentation: All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be

### When DSP were asked to give examples of Abuse, Neglect and Exploitation, the following was reported:

- DSP #210 stated, "Abuse is hitting, Neglect is just bruises everywhere and Exploitation, just getting that word, don't know."
- DSP #204 stated, "I guess I don't know what exploitation means."

made available immediately upon a division		
representative's request. Failure to provide		
employee and volunteer training documentation		
shall subject the community-based service		
provider to the penalties provided for in this rule.		
provider to the penalties provided for in this rule.		
Policy Title: Training Requirements for Direct		
Service Agency Staff Policy - Eff. March 1,		
2007 II. POLICY STATEMENTS:		
A. Individuals shall receive services from		
competent and qualified staff.		
C. Staff shall complete training on DOH-		
C. Stall Shall complete training on DOI1-		
approved incident reporting procedures in		
accordance with 7 NMAC 1.13.		
	1	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Health and Welfare -	The state, on an ongoing basis, identifies,	addresses and seeks to prevent occurrence	es of
abuse, neglect and exploitation. Individua	als shall be afforded their basic human righ	ts. The provider supports individuals to acc	cess
needed healthcare services in a timely ma		•	
Tag #1A08.2 Healthcare Requirements	Standard Level Deficiency		
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.  B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or	Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 4 of 10 individuals receiving Community Inclusion and Living Services.  Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:  Community Inclusion Services ONLY Healthcare Requirements:	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
bevelopmental disabilities supports Division (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications: A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.	Individual #2 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.  Vision Exam     Individual #2 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.  Community Living Services / Community Inclusion Services (Multiple Services):	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.  Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013	<ul> <li>Dental Exam</li> <li>Individual #1 - As indicated by collateral documentation reviewed, the exam was completed on 01/13/2014. As indicated by the DDSD file matrix, Dental Exams are to</li> </ul>		

Chapter 5 (CIES) 3. Agency Requirements H. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy.

Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

- be conducted annually. No evidence of current exam was found.
- Individual #9 As indicated by collateral documentation reviewed, the exam was attempted on 5/14/2014. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found.

#### Vision Exam

- Individual #1 As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. Per nursing note on 8/11/2015, vision exam was attempted but an adequate test could not be completed. No evidence of exam was found.
- Individual #9 As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.

#### Auditory Exam

 Individual #8 - As indicated by collateral documentation reviewed, exam was completed on 9/29/2014. Follow-up was to be completed in 1 year. No evidence of follow-up found.

#### Bone Density Exam

 Individual #8 - As indicated by collateral documentation reviewed, exam was scheduled for 7/17/2015. No evidence of exam results were found.

#### Cholesterol and Blood Glucose

 Individual #9 - As indicated by collateral documentation reviewed, lab work was

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#### Chapter 13 (IMLS) 2. Service Requirements: C. Documents to be maintained in the agency administrative office, include: (This is not an allinclusive list refer to standard as it includes other items)...

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007

CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:

(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;

# CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING G. Health Care Requirements for Community Living Services.

(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the

completed on 3/6/2014. No evidence of lab results were found.

#### **Blood Levels**

 Individual #9 - As indicated by collateral documentation reviewed, lab work for CBC, CMP and TSH was completed on 3/6/2014. No evidence of lab results were found.

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

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

Tag # 1A03 CQI System	Standard Level Deficiency		
STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS d. PROVIDER shall have a Quality Management and Improvement Plan in accordance with the current MF Waiver Standards and/or the DD Waiver Standards specified by the DEPARTMENT. The Quality Management and Improvement Plan for DD Waiver Providers must describe how the PROVIDER will determine that each waiver assurance and requirement is met. The applicable assurances and requirements are: (1) level of care determination; (2) service plan; (3) qualified providers; (4) health and welfare; (5) administrative authority; and, (6) financial accountability. For each waiver assurance, this description must include:  i. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance;  ii. The entities or individuals responsible for conducting the discovery/monitoring processes;  iii. The types of information used to measure performance; and,  iv. The frequency with which performance is measured.	Based on record review and interview, the Agency had not fully implemented their Continuous Quality Management System as required by standard.  • Review of the findings identified during the on-site survey (October 19 – 22, 2015) and as reflected in this report of findings, the Agency had multiple deficiencies noted, including Conditions of Participation out of compliance, which indicates the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →  Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Developmental Disabilities (DD) Waiver Service		
Standards effective 11/1/2012 revised 4/23/2013		
CHAPTER 5 (CIES) 3. Agency Requirements:		
J. Quality Assurance/Quality Improvement		
(QA/QI) Program: Agencies must develop and		
maintain an active QA/QI program in order to		
assure the provision of quality services. This		
includes the development of a QA/QI plan, data		
gathering and analysis, and routine meetings to		
analyze the results of QA/QI activities.		
1. <b>Development of a QA/QI plan:</b> The quality		
management plan is used by an agency to		
continually determine whether the agency is		
performing within program requirements,		
achieving desired outcomes and identifying		
opportunities for improvement. The quality		
management plan describes the process the		
Provider Agency uses in each phase of the		
process: discovery, remediation and		
improvement. It describes the frequency, the		
source and types of information gathered, as		
well as the methods used to analyze and		
measure performance. The quality		
management plan should describe how the data		
collected will be used to improve the delivery of		
services and methods to evaluate whether		
implementation of improvements are working.		
impromonation of improvements are nothing.		
2. Implementing a QA/QI Committee: The		
QA/QI committee must convene on at least a		
quarterly basis and as needed to review service		
reports, to identify any deficiencies, trends,		
patterns or concerns as well as opportunities for		
quality improvement. The QA/QI meeting must		
be documented. The QA/QI review should		
address at least the following:		
a.Implementation of ISPs: extent to which		
services are delivered in accordance with ISPs		
and associated support plans with WDSI		
including the type, scope, amount, duration		
and frequency specified in the ISP as well as		
and hequelley opcomed in the for do well do		

effectiveness of such implementation as indicated by achievement of outcomes;		
indicated by achievement of outcomes,		
3. The Provider Agency must complete a QA/QI		
report annually by February 15th of each		
calendar year or as otherwise requested by		
DOH. The report must be kept on file at the		
agency, made available for review by DOH and		
upon request from DDSD; the report must be		
submitted to the relevant DDSD Regional		
Offices. The report will summarize:		
a. Analysis of General Events Reports data in		
Therap;		
b. Compliance with Caregivers Criminal History		
Screening requirements;		
c. Compliance with Employee Abuse Registry		
requirements;		
d. Compliance with DDSD training		
requirements;		
e. Patterns of reportable incidents;		
f. Results of improvement actions taken in		
previous quarters;		
g. Sufficiency of staff coverage;		
h. Effectiveness and timeliness of		
implementation of ISPs, and associated		
support including trends in achievement of individual desired outcomes;		
i. Results of General Events Reporting data		
analysis;		
j. Action taken regarding individual grievances;		
k. Presence and completeness of required		
documentation;		
I. A description of how data collected as part of		
the agency's QA/QI Plan was used; what		
quality improvement initiatives were		
undertaken and what were the results of		
those efforts, including discovery and		
remediation of any service delivery		
deficiencies discovered through the QA/QI		
process; and		
m Significant program changes		

CHAPTER 6 (CCS) 3. Agency Requirements:		
I. Quality Assurance/Quality Improvement		
(QA/QI) Program: Agencies must develop and		
maintain an active QA/QI program in order to		
assure the provision of quality services. This		
includes the development of a QA/QI plan, data		
gathering and analysis, and routine meetings to		
analyze the results of QI activities.		
1. Development of a QI plan: The quality		
management plan is used by an agency to		
continually determine whether the agency is		
performing within program requirements,		
achieving desired outcomes and identifying		
opportunities for improvement. The quality		
management plan describes the process the		
Provider Agency uses in each phase of the		
process: discovery, remediation and		
improvement. It describes the frequency, the		
source and types of information gathered, as		
well as the methods used to analyze and		
measure performance. The quality		
management plan should describe how the data		
collected will be used to improve the delivery of		
services and methods to evaluate whether		
implementation of improvements are working.		
implementation of improvemente are working.		
2. Implementing a QI Committee: The QA/QI		
committee shall convene at least quarterly and		
as needed to review service reports, to identify		
any deficiencies, trends, patterns or concerns as		
well as opportunities for quality improvement.		
The QA/QI meeting shall be documented. The		
QA/QI review should address at least the		
following:		
a. The extent to which services are delivered in		
accordance with ISPs, associated support		
plans and WDSI including the type, scope,		
amount, duration and frequency specified in		
the ISD as well as effectiveness of such		

implementation as indicated by achievement		
of outcomes;		
b. Analysis of General Events Reports data;		
c. Compliance with Caregivers Criminal History		
Screening requirements;		
d. Compliance with Employee Abuse Registry		
requirements;		
e. Compliance with DDSD training		
requirements;		
f. Patterns of reportable incidents; and		
g. Results of improvement actions taken in		
previous quarters.		
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3. The Provider Agencies must complete a		
QA/QI report annually by February 15th of each		
year, or as otherwise requested by DOH. The		
report must be kept on file at the agency, made		
available for review by DOH and upon request		
from DDSD the report must be submitted to the		
relevant DDSD Regional Offices. The report will		
summarize:		
Sufficiency of staff coverage;		
Effectiveness and timeliness of		
implementation of ISPs, associated support		
plans, and WDSI, including trends in		
achievement of individual desired outcomes;		
c. Results of General Events Reporting data		
analysis;		
I. Action taken regarding individual grievances;		
e. Presence and completeness of required		
documentation;		
f. A description of how data collected as part of		
the agency's QI plan was used; what quality		
improvement initiatives were undertaken and		
what were the results of those efforts,		
including discovery and remediation of any		
service delivery deficiencies discovered		
through the QI process; and		
g. Significant program changes.		

CHAPTER 7 (CIHS) 3. Agency Requirements:	
G. Quality Assurance/Quality Improvement	
(QA/QI) Program: Agencies must develop and	
maintain an active QA/QI program in order to	
assure the provision of quality services. This	
includes the development of a QA/QI plan, data	
gathering and analysis, and routine meetings to	
analyze the results of QA/QI activities.	
1. Development of a QA/QI plan: The quality	
management plan is used by an agency to	
continually determine whether the agency is	
performing within program requirements,	
achieving desired outcomes and identifying	
opportunities for improvement. The quality	
management plan describes the process the	
Provider Agency uses in each phase of the	
process: discovery, remediation and	
improvement. It describes the frequency, the	
source and types of information gathered, as	
well as the methods used to analyze and	
measure performance. The quality	
management plan should describe how the data	
collected will be used to improve the delivery of	
services and methods to evaluate whether	
implementation of improvements are working.	
2. Implementing a QA/QI Committee: The	
QA/QI committee shall convene on at least a	
quarterly basis and as needed to review monthly	
service reports, to identify any deficiencies,	
trends, patterns or concerns as well as	
opportunities for quality improvement. The	
QA/QI meeting must be documented. The	
QA/QI review should address at least the	
following:	
a local amount of the of 100 a. The control of	
a. Implementation of ISPs: The extent to	
which services are delivered in accordance	
with ISPs and associated support plans	
and/or WDSI including the type, scope,	
amount, duration and frequency specified in	

the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;		
b. Analysis of General Events Reports data;		
c. Compliance with Caregivers Criminal History Screening requirements;		
d. Compliance with Employee Abuse Registry requirements;		
e. Compliance with DDSD training requirements;		
f. Patterns of reportable incidents; and		
g. Results of improvement actions taken in previous quarters.		
3. The Provider Agency must complete a QA/QI report annually by February 15 <sup>th</sup> of each calendar year, or as otherwise request by DOH. The report must be kept on file at the agency, made available for review by DOH and, upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:		
a. Sufficiency of staff coverage;		
<ul> <li>Effectiveness and timeliness of implementation of ISPs and associated support plans and/or WDSI, including trends in achievement of individual desired outcomes;</li> </ul>		
<ul> <li>c. Results of General Events Reporting data analysis;</li> </ul>		
d. Action taken regarding individual grievances;		

e. Presence and completeness of required documentation;		
f. A description of how data collected as part of the agency's QA/QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
g. Significant program changes.		
G. Significant program changes.  CHAPTER 11 (FL) 3. Agency Requirements:  H. Quality Improvement/Quality Assurance (QA/QI) Program: Family Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.  1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as		
well as the methods used to analyze and		
measure performance. The quality management plan should describe how the data		
collected will be used to improve the delivery of		
services and methods to evaluate whether		
implementation of improvements are working.		

2. Implementing a QA/QI Committee: The		
QA/QI committee must convene on at least a		
quarterly basis and as needed to review monthly		
service reports, to identify any deficiencies,		
trends, patterns or concerns as well as		
opportunities for quality improvement. The		
QA/QI meeting must be documented. The		
QA/QI review should address at least the		
following:		
a. The extent to which services are delivered in		
accordance with the ISP including the type,		
scope, amount, duration and frequency		
specified in the ISP as well as effectiveness		
of such implementation as indicated by		
achievement of outcomes;		
b. Analysis of General Events Reports data;		
c. Compliance with Caregivers Criminal History		
Screening requirements;		
d. Compliance with Employee Abuse Registry		
requirements;		
e. Compliance with DDSD training		
requirements;		
f. Patterns in reportable incidents; and		
g. Results of improvement actions taken in		
previous quarters.		
P. 2. 1. 2. 10 - 4 - 10 - 10 - 10 - 10 - 10 - 10 -		
3. The Provider Agency must complete a QA/QI		
report annually by February 15th of each year, or		
as otherwise requested by DOH. The report		
must be kept on file at the agency, made		
available for review by DOH and upon request		
from DDSD; the report must be submitted to the		
relevant DDSD Regional Offices. The report will		
summarize:		
<ul> <li>a. Sufficiency of staff coverage;</li> </ul>		
b. Effectiveness and timeliness of		
implementation of ISPs, including trends in		
achievement of individual desired outcomes;		
c Results of General Events Reporting data		

analysis, Trends in category II significant

events;

ction taken regarding individual grievances; resence and completeness of required bournertation; description of how data collected as part the agency's QI plan was used; finat quality improvement initiatives were indertaken and what were the results of lose efforts, including discovery and immediation of any service delivery efficiencies discovered through the QI cocess; and gindificant program changes.  **PTER 12 (SL) 3. Agency Requirements: lality Assurance/Quality Improvement 2) Program: Supported Living Provider cises must develop and maintain an active I program in order to assure the provision ality services. This includes the openent of a QAVQI plan, data gathering nalysis, and routine meetings to analyze susts of QAVQI activities.  **setopment of a QAVQI plan: The quality gement plan is used by an agency to usually determine whether the agency is reming within program requirements, wing desired outcomes and identifying tunities for improvement. The quality gement plan is describes the process the der Agency uses in each phase of the ss. discovery, remediation and wement. It describes the process the ear and yees of information gathered, as is the methods used to analyze and ure performance. The quality gement plan is should describe how the data tend will be used to improve the delivery of sea and methods to evaluate whether.			
documentation; A description of how data collected as part of the agency's QI plan was used; What quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and Significant program changes.  HAPTER 12 (SL) 3. Agency Requirements: Quality Assurance/Quality Improvement AQI) program: Supported Living Provider pencies must develop and maintain an active VQI program in order to assure the provision quality services. This includes the velopment of a QA/QI plan, data gathering d analysis, and routine meetings to analyze a results of QA/QI activities.  Development of a QA/QI plan: The quality anagement plan is used by an agency to nitinually determine whether the agency is froming within program requirements, hieving desired outcomes and identifying portunities for improvement. The quality anagement plan describes the process the ovider Agency uses in each phase of the coses: discovery, remediation and provement. It describes the frequency, the urce and types of information gathered, as all as the methods used to analyze and assure performance. The quality anagement plan should describe how the data liected will be used to improve the delivery of rivices and methods to evaluate whether	Patterns in medication errors;		
f. Presence and completeness of required documentation; g. A description of how data collected as part of the agency's QI plan was used; h. What quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and is Significant program changes.  CHAPTER 12 (SL) 3. Agency Requirements: b. Quality Assurance/Quality Improvement QA/QI) Program: Supported Living Provider gencies must develop and maintain an active DA/QI program in order to assure the provision of quality services. This includes the evelopment of a QA/QI plan, data gathering and analysis, and routine meetings to analyze results of QA/QI patholish years are results of QA/QI patholish years are results of QA/QI patholish years are results of QA/QI plan is used by an agency to ontinually determine whether the agency is erforming within program requirements. chieving desired outcomes and identifying poportunities for improvement. The quality nanagement plan describes the process the Provider Agency uses in each phase of the rocess: discovery, remediation and mprovement. It describes the frequency, the outree and types of information gathered, as well as the methods to evaluate whether	e. Action taken regarding individual grievances;		
g. A description of how data collected as part of the agency's QI plan was used; h. What quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and is. Significant program changes.  CHAPTER 12 (SL) 3. Agency Requirements: 3. Quality Assurance/Quality improvement QA(QI) Program: Supported Living Provider Agencies must develop and maintain an active DA/QI program in order to assure the provision of quality services. This includes the levelopment of a QA/QI plan, data gathering individually evidences and quality exity.  In evelopment of a QA/QI plan, the quality is nearly an analyze her essults of QA/QI activities.  In evelopment of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is serforming within program requirements, suchieving desired outcomes and identifying apportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and mprovement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and neasure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether	f. Presence and completeness of required		
of the agency's Q Iplan was used; h. What quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and i. Significant program changes.  CHAPTER 12 (SL) 3. Agency Requirements: 3. Quality Assurance/Quality Improvement QA/QI) program: Supported Living Provider Agencies must develop and maintain an active DA/QI program: Supported Living Provider Agencies must develop and maintain an active DA/QI program in order to assure the provision of quality services. This includes the levelopment of a QA/QI plan, data gathering and analysis, and routine meetings to analyze he results of QA/QI activities.  1. Development of a QA/QI plan. The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, schieving desired outcomes and identifying poportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the Provider Agency used in each phase of the Provider Agency used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether	documentation;		
h. What quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and i. Significant program changes.  CHAPTER 12 (SL) 3. Agency Requirements:  3. Quality Assurance/Quality Improvement QA/QI) Program: Supported Living Provider Agencies must develop and maintain an active 2A/QI) program in order to assure the provision of quality services. This includes the levelopment of a QA/QI plan, data gathering and analysis, and routine meetings to analyze her results of QA/QI activities.  1. Development of a QA/QI plan. The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, encireving desired outcomes and identifying apportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and mprovement. It describes the frequency, the course and types of information gathered, as well as the methods used to analyze and neasure performance. The quality nanagement plan should describe how the data ollected will be used to improve the delivery of services and methods to evaluate whether	g. A description of how data collected as part		
undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and i. Significant program changes.  CHAPTER 12 (SL) 3. Agency Requirements: 3. Quality Assurance/Quality Improvement QA/QI) Program: Supported Living Provider Agencies must develop and maintain an active DA/QI) program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze he results of QA/QI activities.  I. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, schieving desired outcomes and identifying apportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the phase of	of the agency's QI plan was used;		
those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and i. Significant program changes.  CHAPTER 12 (SL) 3. Agency Requirements: 3. Quality Assurance/Quality Improvement QA/QI) Program: Supported Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the levelopment of a QA/QI plan, data gathering and analysis, and routine meetings to analyze he results of QA/QI activities.  I. Development of a QA/QI plan: The quality hanagement plan is used by an agency is continually determine whether the agency is serforming within program requirements, achieving desired outcomes and identifying hyportunities for improvement. The quality hanagement plan describes the process the Provider Agency uses in each phase of the phase of t	h. What quality improvement initiatives were		
remediation of any service delivery deficiencies discovered through the QI process; and i. Significant program changes.  CHAPTER 12 (SL) 3. Agency Requirements: 3. Quality Assurance/Quality Improvement QA/QI) Program: Supported Living Provider Agencies must develop and maintain an active AA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI plan, that quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, inchieving desired outcomes and identifying apportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and mprovement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and neasure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether			
deficiencies discovered through the QI process; and i. Significant program changes.  CHAPTER 12 (SL) 3. Agency Requirements: 3. Quality Assurance/Quality Improvement QA/QI) Program: Supported Living Provider Agencies must develop and maintain an active 2A/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze he results of QA/QI activities.  I. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying apportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and mprovement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and necessure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether			
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management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether			
collected will be used to improve the delivery of services and methods to evaluate whether			
services and methods to evaluate whether			
	implementation of improvements are working.		

2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:  a. Implementation of the ISP and the extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration, and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;  b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History		
<ul> <li>c. Compliance with Caregivers Criminal History Screening requirements;</li> <li>d. Compliance with Employee Abuse Registry requirements;</li> </ul>		
<ul> <li>e. Compliance with DDSD training requirements;</li> </ul>		
<ul> <li>f. Patterns in reportable incidents; and</li> <li>g. Results of improvement actions taken in previous quarters.</li> </ul>		
2. The Provider Agency must complete a QA/QI report annually by February 15 <sup>th</sup> of each calendar year, or as otherwise requested by		
DOH. The report must be kept on file at the agency, made available for review by DOH, and		
upon request from DDSD the report must be submitted to the relevant DDSD Regional		
Offices. The report will summarize:		
<ul><li>a. Sufficiency of staff coverage;</li><li>b. Effectiveness and timeliness of</li></ul>		
implementation of ISPs, including trends in achievement of individual desired outcomes;		

c. Results of General Events Reporting data analysis, Trends in Category II significant events: d. Patterns in medication errors: e. Action taken regarding individual grievances; f. Presence and completeness of required documentation: g. A description of how data collected as part of the agency's QA/QI plan was used, what quality improvement initiatives were undertaken, and the results of those efforts. including discovery and remediation of any service delivery deficiencies discovered through the QI process; and h. Significant program changes. CHAPTER 13 (IMLS) 3. Service Requirements: F. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities. 1. Development of a QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and

measure performance. The quality

management plan should describe how the data collected will be used to improve the delivery of

services and methods to evaluate whether		
implementation of improvements are working.		
<ol><li>Implementing a QA/QI Committee: The</li></ol>		
QA/QI committee shall convene on at least on a		
quarterly basis and as needed to review service		
reports, to identify any deficiencies, trends,		
patterns or concerns, as well as opportunities for		
quality improvement. For Intensive Medical		
Living providers, at least one nurse shall be a		
member of this committee. The QA meeting		
shall be documented. The QA review should		
address at least the following:		
a. Implementation of the ISPs, including the		
extent to which services are delivered in		
accordance with the ISPs and associated		
support plans and /or WDSI including the type,		
scope, amount, duration, and frequency		
specified in the ISPs as well as effectiveness		
of such implementation as indicated by		
achievement of outcomes;		
b. Trends in General Events as defined by		
DDSD;		
c. Compliance with Caregivers Criminal History		
Screening Requirements;		
d. Compliance with DDSD training requirements;		
e. Trends in reportable incidents; and		
f. Results of improvement actions taken in		
previous quarters.		
3. The Provider Agency must complete a QA/QI		
report annually by February 15th of each		
calendar year, or as otherwise requested by		
DOH. The report must be kept on file at the		
agency, made available for review by DOH and		
upon request from DDSD; the report must be		
submitted to the relevant DDSD Regional		
Offices. The report will summarizes:		
Sufficiency of staff coverage;		
b. Effectiveness and timeliness of		
implementation of ISPs and associated	1	1

Support plans and/or WDSI including trends		
in achievement of individual desired		
outcomes;		
c. Trends in reportable incidents;		
<ul> <li>d. Trends in medication errors;</li> </ul>		
e. Action taken regarding individual grievances;		
f. Presence and completeness of required		
documentation;		
g. How data collected as part of the agency's		
QA/QI was used, what quality improvement		
initiatives were undertaken, and what were		
the results of those efforts, including		
discovery and remediation of any service		
delivery deficiencies discovered through the		
QI process; and		
h. Significant program changes.		
CHAPTER 14 (ANS) 3. Service		
Requirements: N. Quality Assurance/Quality		
Improvement (QA/QI) Program: Agencies		
must develop and maintain an active QA/QI		
program in order to assure the provision of		
quality services. This includes the development		
of a QA/QI plan, data gathering and analysis,		
and routine meetings to analyze the results of		
QI activities.		
<ol> <li>Development of a QI plan: The quality</li> </ol>		
management plan is used by an agency to		
continually determine whether the agency is		
performing within program requirements,		
achieving desired outcomes and identifying		
opportunities for improvement. The quality		
management plan describes the process the		
Provider Agency uses in each phase of the		
process: discovery, remediation and		
improvement. It describes the frequency, the		
source and types of information gathered, as well as the methods used to analyze and		
measure performance. The quality		
management plan should describe how the data		
management plan should describe now the data		

collected will be used to improve the delivery of

services and methods to evaluate whether		
implementation of improvements are working.		
2. Implementing a QA/QI Committee: The		
QA/QI committee shall convene on at least on a		
quarterly basis and as needed to review service		
reports, to identify any deficiencies, trends,		
patterns or concerns, as well as opportunities for		
quality improvement. For Intensive Medical		
Living providers, at least one nurse shall be a		
member of this committee. The QA meeting		
shall be documented. The QA review should		
address at least the following:		
Trends in General Events as defined by DDSD;		
b. Compliance with Caregivers Criminal History		
Screening Requirements;		
c. Compliance with DDSD training		
requirements;		
d. Trends in reportable incidents; and		
e. Results of improvement actions taken in		
previous quarters.		
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3. The Provider Agency must complete a QA/QI		
report annually by February 15th of each		
calendar year, or as otherwise requested by		
DOH. The report must be kept on file at the		
agency, made available for review by DOH and		
upon request from DDSD; the report must be		
submitted to the relevant DDSD Regional		
Offices. The report will summarizes:		
a. Sufficiency of staff coverage;		
b. Trends in reportable incidents;		
c. Trends in medication errors;		
d. Action taken regarding individual grievances;		
e. Presence and completeness of required		
documentation;		
f. How data collected as part of the agency's		
QA/QI was used, what quality improvement initiatives were undertaken, and what were		
the results of those efforts, including		

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

Based on interview, the Agency did not ensure Agency Brovider:  REALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER  AGREEMENT ARTICLE 14. STANDARDS FOR SERVICES AND LICENSING  a. The PROVIDER agrees to provide services as set forth in the Scope of Service, in accordance with all applicable regulations and standards including the current DD Waiver Service Standards and MF Waiver Service Standards.  ARTICLE 39. POLICIES AND REGULATIONS Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD  PROVIDER APPLICATION NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014 Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's interview. The procedures is a service of the procedures in the standards interview, the Agency did not ensure Agency the Agency and procedures for 1 of 9 Agency Personnel.  Based on interview, the Agency did the Agency did not ensure Agency and procedures for 1 of 9 Agency Personnel.  When DSP were asked if the agency had an oncall procedure, the following was reported:  ■ DSP #209 stated, "Call house manager, if she doesn't answer, call the staff I guess." (Individual #9) Per Agency's on-call policy, DSP are to follow the chain of command and contact the Executive Director if other managers cannot be reached.  Provider:  Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →  Provider:  Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →  Provider:  Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →  Provider:  Enter your ongoing Quality	Tag # 1A06	Standard Level Deficiency		
Agency Personnel were aware of the Agency's On-Call Policy and Procedures for 1 of 9 Agency SupPorts Division Provides services and LicEnsing as set forth in the Scope of Service, in accordance with all applicable regulations and standards including the current DD Waiver Service Standards.  ARTICLE 39. POLICIES AND REGULATIONS Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD  PROVIDER APPLICATION NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014 Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures;  i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD	Policy and Procedure Requirements			
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accordance with all applicable regulations and standards including the current DD Waiver Service Standards and MF Waiver Service Standards.  ARTICLE 39. POLICIES AND REGULATIONS Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD  PROVIDER APPLICATION NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014 Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's  i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD		can procedure, the following was reported.		
standards including the current DD Waiver Service Standards and MF Waiver Service Standards.  ARTICLE 39. POLICIES AND REGULATIONS Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD  PROVIDER APPLICATION NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014  Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) the DDSD Service Standards, please provide your agency's i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD		DSP #209 stated "Call house manager if		
Service Standards and MF Waiver Service Standards.  (Individual #9) Per Agency's on-call policy, DSP are to follow the chain of command and contact the Executive Director if other managers cannot be reached.  Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD  PROVIDER APPLICATION NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014  Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's  i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD				
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ARTICLE 39. POLICIES AND REGULATIONS Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD  PROVIDER APPLICATION NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014 Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's i. Emergency and on-call procedures; 3. Additional Program Descriptions for DD				
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reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD  PROVIDER APPLICATION NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014  Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's  i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD	Provider Agreements and amendments	3	Provider:	
PROVIDER APPLICATION NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014 Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's  i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD	reference and incorporate laws, regulations,		Enter your ongoing Quality Assurance/Quality	
PROVIDER APPLICATION NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014 Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD	policies, procedures, directives, and contract		Improvement processes as it related to this tag	
DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014 Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's i. Emergency and on-call procedures; 3. Additional Program Descriptions for DD	provisions not only of DOH, but of HSD		number here: →	
DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014 Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's i. Emergency and on-call procedures; 3. Additional Program Descriptions for DD	-			
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014 Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD				
DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014 Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD				
Effective 10/1/2012 Revised 3/2014 Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD				
Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD				
2. DD Waiver Policy and Procedures (coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's i. Emergency and on-call procedures; 3. Additional Program Descriptions for DD				
(coversheet and page numbers required) d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD				
d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency's  i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD				
receiving services, as required in the DDSD Service Standards, please provide your agency's  i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD				
Service Standards, please provide your agency's  i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD				
i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD				
i. Emergency and on-call procedures;  3. Additional Program Descriptions for DD				
3. Additional Program Descriptions for DD	agency's			
	i. Emergency and on-call procedures;			
Waiver Adult Nursing Services (coversheet	3. Additional Program Descriptions for DD			
and page numbers required)	Waiver Adult Nursing Services (coversheet and page numbers required)			

a. Describe your agency's arrangements for on- call nursing coverage to comply with PRN aspects of the DDSD Medication Assessment and Delivery Policy and Procedure as well as response to individuals changing condition/unanticipated health related events;		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013		
Chapter 11 (FL) 2. Service Requirement I. Health Care Requirements for Family Living:  9. Family Living Provider Agencies are required to be an Adult Nursing provider and have a Registered Nurse (RN) licensed by the State of New Mexico on staff and residing in New Mexico or bordering towns see: Adult Nursing requirements. The agency nurse may be an employee or a sub-contractor. b. On-call nursing services: An on-call nurse must be available to surrogate or host families DSP for medication oversight. It is expected that no single nurse carry the full burden of on-call duties for the agency.		
Chapter 12 (SL) 2. Service Requirements L. Training Requirements. 6. Nursing Requirements and Roles: d. On-call nursing services: An on-call nurse must be available to DSP during the periods when a nurse is not present. The on-call nurse must be able to make an on-site visit when information provided by DSP over the phone indicate, in the nurse's professional judgment, a need for a face to face assessment to determine appropriate action. An LPN taking on-call must have access to their RN supervisor by phone during their on-call shift in case consultation is required. It is expected that no single nurse carry the full burden of on-call duties for the agency and that nurses be		

appropriately compensated for taking their turn covering on-call shifts.		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007		
CHAPTER 1. II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency		
policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency		
staff, whether directly employed or subcontracting with the Provider Agency.		
Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.		
B. Provider Agency Policy and Procedure Requirements: All Provider Agencies, in		
addition to requirements under each specific		
service standard shall at a minimum develop, implement and maintain, at the designated		
Provider Agency main office, documentation of policies and procedures for the following:		
(1) Coordination of Provider Agency staff serving individuals within the program		
which delineates the specific roles of agency staff, including expectations for		
coordination with interdisciplinary team		
members who do not work for the provider agency;		
(2) Response to individual emergency medical situations, including staff training		
for emergency response and on-call systems as indicated; and		
(3) Agency protocols for disaster planning and emergency preparedness.		

Tag # 1A09	Standard Level Deficiency		
Medication Delivery			
Routine Medication Administration			
NMAC 16.19.11.8 MINIMUM STANDARDS:	Medication Administration Records (MAR) were	Provider:	
A. MINIMUM STANDARDS FOR THE	reviewed for the months of September and	State your Plan of Correction for the	
DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:	October 2015.	deficiencies cited in this tag here: →	
(d) The facility shall have a Medication	Based on record review, 4 of 7 individuals had		
Administration Record (MAR) documenting	Medication Administration Records (MAR),		
medication administered to residents,	which contained missing medications entries		
including over-the-counter medications.	and/or other errors:		
This documentation shall include:			
(i) Name of resident;	Individual #3		
(ii) Date given;	October 2015		
(iii) Drug product name;	As indicated by the Medication Administration		
(iv) Dosage and form;	Records and Physician's Orders the individual		
<ul><li>(v) Strength of drug;</li></ul>	is to take Polyethylene Glycol 17gm/1 dose		
(vi) Route of administration;	powder daily 4 times a week. However,	Provider:	
(vii) How often medication is to be taken;	according to the Medication Administration	Enter your ongoing Quality Assurance/Quality	
(viii) Time taken and staff initials;	Record during on-site visit on 10/19/2015,	Improvement processes as it related to this tag	
(ix) Dates when the medication is	Polyethylene Glycol 17gm/1 dose powder was	number here: →	
discontinued or changed;	being given daily 10/1 – 19, 2015 (8 AM).		
(x) The name and initials of all staff			
administering medications.	Medication Administration Records contained		
Madal Ovetadial Dusas duna Manual	missing entries. No documentation found		
Model Custodial Procedure Manual	indicating reason for missing entries:		
D. Administration of Drugs	• Nuedexta 20 mg – 10 mg (1 time daily) –		
Unless otherwise stated by practitioner,	Blank 10/19 (8 AM)		
patients will not be allowed to administer their	\( \frac{1}{2} \) \( \frac{1} \) \( \frac{1}{2} \) \( \frac{1}{2} \) \( \frac{1}{2} \) \( \frac{1} \) \( \frac{1} \) \( \frac{1}2 \) \( \frac{1}2 \) \( \fra		
own medications. Document the practitioner's order authorizing	Vitamin D 400 units (1 time daily) – Blank     (2.40.40.40.40.40.40.40.40.40.40.40.40.40.		
the self-administration of medications.	10/19 (8 AM)		
the sell-autilitistration of medications.	Pieto e Ocalicata e Oct (Octobre 1911)		
All PRN (As needed) medications shall have	Biotene Oralbalance Gel (2 times daily) –  Blank 40(40 (9 AM))		
complete detail instructions regarding the	Blank 10/19 (8 AM)		
administering of the medication. This shall	0-12-0-21-4-050-0-75-0-500-7-1-1-1		
include:	Calcium carb 1,250 mg/5 ml 500mg/ml oral     The state of the sta		
<ul><li>symptoms that indicate the use of the</li></ul>	supplement (2 times daily) – Blank 10/19 (8		
medication,	AM)		
<ul><li>exact dosage to be used, and</li></ul>			

> the exact amount to be used in a 24 hour period.

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 1. Scope of Service B. Self Employment 8. Providing assistance with medication delivery as outlined in the ISP; C. Individual Community Integrated Employment 3. Providing assistance with medication delivery as outlined in the ISP; D. Group Community Integrated Employment 4. Providing assistance with medication delivery as outlined in the ISP; and

**B. Community Integrated Employment Agency Staffing Requirements: o.** Comply with DDSD Medication Assessment and Delivery Policy and Procedures;

CHAPTER 6 (CCS) 1. Scope of Services A. Individualized Customized Community
Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. C. Small Group Customized Community
Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. D. Group Customized Community Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy.

# **CHAPTER 11 (FL) 1 SCOPE OF SERVICES A. Living Supports- Family Living Services:**

The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT):

**19.** Assisting in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy,

- Cranberry Fruit 405mg capsule (2 times daily) – Blank 10/19 (8 AM)
- Docusate Sodium 50mg/5ml liquid (2 times daily) – Blank 10/19 (8 AM)
- Bupropion HCL SR F/C 150mg Tablet ER (1 time daily) – Blank 10/19 (8 AM)
- Citalopram HBR 20mg Tablet (1 time daily)
   Blank 10/19 (8 AM)
- Dasetta 1mg 35mcg Tablet (1 time daily) -Blank 10/19 (8 AM)

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

Dasetta 1mg – 35mcg Tablet (1 time daily)

Individual #4

October 2015

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

- Victoza 3-pack 0.6 mg/0.1ml (1 time daily) Blank 10/17, 18 (8 AM)
- Aripiprazole 10mg (1 time daily) Blank 10/17, 18 (8AM)

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

Aripiprazole 10mg (1 time daily)

Individual #5 September 2015

QMB Report of Findings – Community Options, Inc. – Northeast Region – October 19 – 22, 2015

New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate: and

## I. Healthcare Requirements for Family Living.

- 3. B. Adult Nursing Services for medication oversight are required for all surrogate Lining Supports- Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication.
- **6.** Support Living- Family Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations.
- a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;
- b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:
  - i.The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed:

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

 Lorazepam 0.5mg (1 time daily) – Blank 9/13 (7 PM)

Individual #8

October 2015

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

 Bydureon Latex-Free 2mg vial (1 time weekly) – Blank 10/13 (8 AM)

i	i.Prescribed dosage, frequency and		
	method/route of administration, times and		
	dates of administration;		
ii	i.Initials of the individual administering or		
	assisting with the medication delivery;		
i۱	v.Explanation of any medication error;		
	v.Documentation of any allergic reaction or		
	adverse medication effect; and		
V	i.For PRN medication, instructions for the use		
	of the PRN medication must include		
	observable signs/symptoms or		
	circumstances in which the medication is to		
	be used, and documentation of effectiveness		
	of PRN medication administered.		
c.	The Family Living Provider Agency must		
	also maintain a signature page that		
	designates the full name that corresponds to		
	each initial used to document administered		
	or assisted delivery of each dose; and		
d.	Information from the prescribing pharmacy		
	regarding medications must be kept in the		
	home and community inclusion service		
	locations and must include the expected		
	desired outcomes of administering the		
	medication, signs and symptoms of adverse		
	events and interactions with other		
	medications.		
e.	Medication Oversight is optional if the		
	individual resides with their biological family		
	(by affinity or consanguinity). If Medication		
	Oversight is not selected as an Ongoing		
	Nursing Service, all elements of medication		
	administration and oversight are the sole		
	responsibility of the individual and their		
	biological family. Therefore, a monthly		
	medication administration record (MAR) is		
	not required unless the family requests it		
	and continually communicates all medication		
	changes to the provider agency in a timely		
	manner to insure accuracy of the MAR.		

<ul> <li>i. The family must communicate at least annually and as needed for significant change of condition with the agency nurse regarding the current medications and the individual's response to medications for purpose of accurately completing required nursing assessments.</li> <li>ii. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not deliver medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a Certified Medication Aide (CMA). Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements.</li> <li>iii. If the substitute care provider is a surrogate (not related by affinity or consanguinity) Medication Oversight must be selected and provided.</li> </ul>		
CHAPTER 12 (SL) 2. Service Requirements L. Training and Requirements: 3. Medication Delivery: Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.		
h. All twenty-four (24) hour residential home		

individuals must be licensed by the Board of

Pharmacy, per current regulations;

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

locations and must include the expected desired outcomes of administrating the medication, signs, and symptoms of adverse events and interactions with other		
medications.		
CHAPTER 13 (IMLS) 2. Service Requirements. B. There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations.		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:		
E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing		
services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors		
in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.		
(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be		
maintained and include:  (a) The name of the individual, a transcription of the physician's written or		
licensed health care provider's prescription including the brand and		
generic name of the medication,		

	diagnosis for which the medication is		
<i>(</i> 1.)	prescribed;		
(b)	Prescribed dosage, frequency and		
	method/route of administration, times		
	and dates of administration;		
(c)	Initials of the individual administering or		
	assisting with the medication;		
(d)	Explanation of any medication		
	irregularity;		
(e)	Documentation of any allergic reaction		
	or adverse medication effect; and		
(f)	For PRN medication, an explanation for		
	the use of the PRN medication shall		
	include observable signs/symptoms or		
	circumstances in which the medication		
	is to be used, and documentation of		
	effectiveness of PRN medication		
	administered.		
	e Provider Agency shall also maintain a		
	ure page that designates the full name		
	rresponds to each initial used to		
	ent administered or assisted delivery of		
each o			
	ARs are not required for individuals		
	pating in Independent Living who self-		
	ster their own medications;		
	ormation from the prescribing pharmacy		
	ing medications shall be kept in the		
	and community inclusion service		
	ns and shall include the expected		
	d outcomes of administrating the		
	ation, signs and symptoms of adverse		
events	and interactions with other medications;		

Tag # 1A09.1	Standard Level Deficiency		
Medication Delivery	-		
PRN Medication Administration			
NMAC 16.19.11.8 MINIMUM STANDARDS:	Medication Administration Records (MAR) were	Provider:	
A. MINIMUM STANDARDS FOR THE	reviewed for the months of September and	State your Plan of Correction for the	1 1
DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:	October, 2015.	deficiencies cited in this tag here: →	
(d) The facility shall have a Medication	Based on record review, 4 of 7 individuals had		
Administration Record (MAR) documenting	PRN Medication Administration Records (MAR),		
medication administered to residents,	which contained missing elements as required		
including over-the-counter medications.	by standard:		
This documentation shall include:			
(i) Name of resident;	Individual #3		
(ii) Date given;	October 2015		
(iii) Drug product name;	No evidence of documented Signs/Symptoms		
(iv) Dosage and form;	were found for the following PRN medication:		
(v) Strength of drug;	<ul> <li>Patanol 0.1% drops – PRN – 10/6, 7, 8, 18</li> </ul>		
(vi) Route of administration;	(given 1 time)	Provider:	
(vii) How often medication is to be taken;		Enter your ongoing Quality Assurance/Quality	
(viii) Time taken and staff initials;	No Effectiveness was noted on the	Improvement processes as it related to this tag	
(ix) Dates when the medication is	Medication Administration Record for the	number here: →	
discontinued or changed;	following PRN medication:		
(x) The name and initials of all staff	<ul> <li>Patanol 0.1% drops – PRN – 10/6, 7, 8, 18</li> </ul>		
administering medications.	(given 1 time)		
Model Custodial Procedure Manual	Individual #4		
D. Administration of Drugs	October 2015		
Unless otherwise stated by practitioner,	No evidence of documented Signs/Symptoms		
patients will not be allowed to administer their	were found for the following PRN medication:		
own medications.	<ul> <li>Diphenhydramine HCL 25mg – PRN – 10/8</li> </ul>		
Document the practitioner's order authorizing	(given 1 time)		
the self-administration of medications.	,		
	No Effectiveness was noted on the		
All PRN (As needed) medications shall have	Medication Administration Record for the		
complete detail instructions regarding the	following PRN medication:		
administering of the medication. This shall	<ul> <li>Diphenhydramine HCL 25mg – PRN – 10/8</li> </ul>		
include:	(given 1 time)		
symptoms that indicate the use of the			
medication,	Individual #5		
exact dosage to be used, and	September 2015		

> the exact amount to be used in a 24 hour period.

Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy

### - Eff. November 1, 2006

#### F. PRN Medication

- 3. Prior to self-administration, selfadministration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.
- 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).

# **H. Agency Nurse Monitoring**

1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications.

No evidence of documented Signs/Symptoms were found for the following PRN medication:

• Ketoconazole 2% cream – PRN – 9/3, 6, 7, 10, 14, 17, 21, 24, 28 (given 1 time)

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:

• Ketoconazole 2% cream − PRN − 9/3, 6, 7, 10, 14, 17, 21, 24, 28 (given 1 time)

#### October 2015

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:

Ketoconazole 2% cream – PRN – 10/1;
(given 1 time), 10/2, 3 (given 2 times), 10/4,
9, 10, 16, 17, 18 (given 1 time)

Individual #10 October 2015

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:

 Mapap Acetaminophen 325mg – PRN – 10/8 (given 1 time)

QMB Report of Findings – Community Options, Inc. – Northeast Region – October 19 – 22, 2015

The frequency and type of monitoring must be		
based on the nurse's assessment of the		
individual and consideration of the individual's		
diagnoses, health status, stability, utilization of		
PRN medications and level of support required		
by the individual's condition and the skill level		
and needs of the direct care staff. Nursing		
monitoring should be based on prudent nursing		
practice and should support the safety and		
independence of the individual in the		
community setting. The health care plan shall		
reflect the planned monitoring of the		
individual's response to medication.		
marriadar e respense te medication.		
Department of Health Developmental		
Disabilities Supports Division (DDSD) -		
Procedure Title:		
Medication Assessment and Delivery		
Procedure Eff Date: November 1, 2006		
C. 3. Prior to delivery of the PRN, direct		
support staff must contact the agency nurse to		
describe observed symptoms and thus assure		
that the PRN is being used according to		
instructions given by the ordering PCP. In		
cases of fever, respiratory distress (including		
coughing), severe pain, vomiting, diarrhea,		
change in responsiveness/level of		
consciousness, the nurse must strongly		
consider the need to conduct a face-to-face		
assessment to assure that the PRN does not		
mask a condition better treated by seeking		
medical attention. (References: Psychotropic		
Medication Use Policy, Section D, page 5 Use		
of PRN Psychotropic Medications; and, Human		
Rights Committee Requirements Policy,		
Section B, page 4 Interventions Requiring		
Review and Approval – Use of PRN		
Medications).		

a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.		
4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013		
CHAPTER 11 (FL) 1 SCOPE OF SERVICES  A. Living Supports- Family Living Services: The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT):  19. Assisting in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and  I. Healthcare Requirements for Family Living.  3. B. Adult Nursing Services for medication oversight are required for all surrogate Lining Supports- Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing Services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication.		
6. Support Living- Family Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in		
accordance with DDSD Medication Assessment		

and Delivery Policy and Procedures, the New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations.		
f. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations; g. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:		
i.The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; ii.Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii.Initials of the individual administering or assisting with the medication delivery; iv.Explanation of any medication error; v.Documentation of any allergic reaction or adverse medication effect; and vi.For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.		
h. The Family Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and i. Information from the prescribing pharmacy regarding medications must be kept in the		

	home and community inclusion service	
	locations and must include the expected	
	desired outcomes of administering the	
	medication, signs and symptoms of adverse	
	events and interactions with other	
	medications.	
j.	Medication Oversight is optional if the	
	individual resides with their biological family	
	(by affinity or consanguinity). If Medication	
	Oversight is not selected as an Ongoing	
	Nursing Service, all elements of medication	
	administration and oversight are the sole	
	responsibility of the individual and their	
	biological family. Therefore, a monthly	
	medication administration record (MAR) is	
	not required unless the family requests it	
	and continually communicates all medication	
	changes to the provider agency in a timely	
	manner to insure accuracy of the MAR.	
i١	The family must communicate at least	
	annually and as needed for significant	
	change of condition with the agency nurse	
	regarding the current medications and the	
	individual's response to medications for	
	purpose of accurately completing required	
	nursing assessments.	
١	v. As per the DDSD Medication Assessment	
	and Delivery Policy and Procedure, paid	
	DSP who are not related by affinity or	
	consanguinity to the individual may not	
	deliver medications to the individual unless	
	they have completed Assisting with	
	Medication Delivery (AWMD) training. DSP	
	may also be under a delegation relationship	
	with a DDW agency nurse or be a Certified	
	Medication Aide (CMA). Where CMAs are	
	used, the agency is responsible for	
	maintaining compliance with New Mexico	
	Board of Nursing requirements.	
٧	i. If the substitute care provider is a surrogate	
	(not related by affinity or consanguinity)	

Medication Oversight must be selected and provided.		
CHAPTER 12 (SL) 2. Service Requirements L. Training and Requirements: 3. Medication Delivery: Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.		
<ol> <li>All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;</li> </ol>		
n. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:		
<ul> <li>i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;</li> </ul>		
<ul> <li>ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;</li> </ul>		
iii. Initials of the individual administering or assisting with the medication delivery;		
iv. Explanation of any medication error;		

	v. Documentation of any allergic reaction or adverse medication effect; and			
,	vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.			
n.	The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and			
0.	Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administrating the medication, signs, and symptoms of adverse events and interactions with other medications.			
W M w m of M re	equirements. B. There must be compliance ith all policy requirements for Intensive ledical Living Service Providers, including ritten policy and procedures regarding ledication delivery and tracking and reporting if medication errors consistent with the DDSD ledication Delivery Policy and Procedures, elevant Board of Nursing Rules, and harmacy Board standards and regulations.			
S	evelopmental Disabilities (DD) Waiver ervice Standards effective 4/1/2007 HAPTER 1 II. PROVIDER AGENCY			

**REQUIREMENTS:** The objective of these

standards is to establish Provider Agency	
policy, procedure and reporting requirements	
for DD Medicaid Waiver program. These	
requirements apply to all such Provider Agency	
staff, whether directly employed or	
subcontracting with the Provider Agency.	
Additional Provider Agency requirements and	
personnel qualifications may be applicable for	
specific service standards.	
E. Medication Delivery: Provider Agencies	
that provide Community Living, Community	
Inclusion or Private Duty Nursing services shall	
have written policies and procedures regarding	
medication(s) delivery and tracking and	
reporting of medication errors in accordance	
with DDSD Medication Assessment and	
Delivery Policy and Procedures, the Board of	
Nursing Rules and Board of Pharmacy	
standards and regulations.	
(2) When required by the DDSD Medication	
Assessment and Delivery Policy, Medication	
Administration Records (MAR) shall be	
maintained and include:	
(a) The name of the individual, a	
transcription of the physician's written or	
licensed health care provider's	
prescription including the brand and	
generic name of the medication,	
diagnosis for which the medication is	
prescribed;	
(b) Prescribed dosage, frequency and	
method/route of administration, times	
and dates of administration;	
(c) Initials of the individual administering or	
assisting with the medication;	
(d) Explanation of any medication	
irregularity;	
(e) Documentation of any allergic reaction	
or adverse medication effect; and	

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.		
(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;		
(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;		
(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;		

Tag # 1A09.2	Standard Level Deficiency		
Medication Delivery			
Nurse Approval for PRN Medication			
Department of Health Developmental	Based on record review, the Agency did not	Provider:	
Disabilities Supports Division (DDSD)	maintain documentation of PRN usage as	State your Plan of Correction for the	
Medication Assessment and Delivery Policy	required by standard for 3 of 7 Individuals.	deficiencies cited in this tag here: →	
- Eff. November 1, 2006			
F. PRN Medication	Individual #3		
3. Prior to self-administration, self-	October 2015		
administration with physical assist or assisting	No documentation of the verbal authorization		
with delivery of PRN medications, the direct	from the Agency nurse prior to each		
support staff must contact the agency nurse to	administration/assistance of PRN medication		
describe observed symptoms and thus assure	was found for the following PRN medication:		
that the PRN medication is being used	<ul> <li>Patanol 0.1% drops – PRN – 10/6, 7, 8, 18</li> </ul>		
according to instructions given by the ordering	(given 1 time)		
PCP. In cases of fever, respiratory distress			
(including coughing), severe pain, vomiting,	Individual #5		
diarrhea, change in responsiveness/level of	October 2015	Provider:	
consciousness, the nurse must strongly	No documentation of the verbal authorization	Enter your ongoing Quality Assurance/Quality	
consider the need to conduct a face-to-face	from the Agency nurse prior to each	Improvement processes as it related to this tag	
assessment to assure that the PRN does not	administration/assistance of PRN medication	number here: →	
mask a condition better treated by seeking	was found for the following PRN medication:		
medical attention. This does not apply to home	• Ketoconazole 2% cream – PRN – 9/3, 6, 7,		
based/family living settings where the provider	10, 14, 17, 21, 24, 28 (given 1 time)		
is related by affinity or by consanguinity to the individual.			
individual.	Individual #10		
4. The agency pures shall review the utilization	October 2015		
4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or	No documentation of the verbal authorization		
escalating use of PRN medications must be	from the Agency nurse prior to each		
reported to the PCP and discussed by the	administration/assistance of PRN medication		
Interdisciplinary for changes to the overall	was found for the following PRN medication:		
support plan (see Section H of this policy).	Mapap Acetaminophen 325mg – PRN –  40/9 (river 4 time)		
H. Agency Nurse Monitoring	10/8 (given 1 time)		
Regardless of the level of assistance with			
medication delivery that is required by the			
individual or the route through which the			
medication is delivered, the agency nurses			
must monitor the individual's response to the			
effects of their routine and PRN medications.			
The frequency and type of monitoring must be			

based on the nurse's assessment of the		
individual and consideration of the individual's		
diagnoses, health status, stability, utilization of		
PRN medications and level of support required		
by the individual's condition and the skill level		
and needs of the direct care staff. Nursing		
monitoring should be based on prudent nursing		
practice and should support the safety and		
independence of the individual in the		
community setting. The health care plan shall		
reflect the planned monitoring of the		
individual's response to medication.		
Department of Health Developmental		
Disabilities Supports Division (DDSD) -		
Procedure Title: Medication Assessment		
and Delivery Procedure Eff Date: November		
1, 2006		
C. 3. Prior to delivery of the PRN, direct		
support staff must contact the agency nurse to		
describe observed symptoms and thus assure		
that the PRN is being used according to		
instructions given by the ordering PCP. In		
cases of fever, respiratory distress (including		
coughing), severe pain, vomiting, diarrhea,		
change in responsiveness/level of		
consciousness, the nurse must strongly		
consider the need to conduct a face-to-face		
assessment to assure that the PRN does not		
mask a condition better treated by seeking		
medical attention. (References: Psychotropic		
Medication Use Policy, Section D, page 5 Use		
of PRN Psychotropic Medications; and, Human		
Rights Committee Requirements Policy,		
Section B, page 4 Interventions Requiring		
Review and Approval – Use of PRN		
Medications).		
a. Document conversation with nurse including		
all reported signs and symptoms, advice given		
and action taken by staff.		

4. Document on the MAR each time a PRN		
medication is used and describe its effect on the		
individual (e.g., temperature down, vomiting		
lessened, anxiety increased, the condition is the		
same, improved, or worsened, etc.).		
Developmental Disabilities (DD) Waiver Service		
Standards effective 11/1/2012 revised 4/23/2013		
CHAPTER 5 (CIES) 3. Agency Requirements.		
B. Community Integrated Employment		
Agency Staffing Requirements: O. Comply		
with DDSD Medication Assessment and Delivery		
Policy and Procedures; <b>P</b> . Meet the health,		
medication and pharmacy needs during the time		
the individual receives Community Integrated		
Employment if applicable;		
CHAPTER 6 (CCS) 1. Scope of Service A.		
Individualized Customized Community		
<b>Supports 19.</b> Providing assistance or supports		
with medications in accordance with DDSD		
Medication Assessment and Delivery policy; <b>B.</b>		
Community Inclusion Aide 6. Providing		
assistance or supports with medications in		
accordance with DDSD Medication Assessment		
and Delivery policy; C. Small Group		
Customized Community Supports 19.		
Providing assistance or supports with		
medications in accordance with DDSD		
Medication Assessment and Delivery policy; <b>D.</b>		
Group Customized Community Supports 19.		
Providing assistance or supports with		
medications in accordance with DDSD		
Medication Assessment and Delivery policy;		
CHAPTER 11 (FL) 1. Scope of Service. A.		
Living Supports – Family Living Services 19.		
Assisting in medication delivery, and related		
monitoring, in accordance with the DDSD's		
Medication Assessment and Delivery Policy,		
New Mexico Nurse Practice Act, and Board of		

Pharmacy regulations including skill

development activities leading to the ability for individuals to self-administer medication as appropriate; and  3. Family Living Providers are required to provide Adult Nursing Services and complete the scope of services for nursing assessments and consultation as outlined in the Adult Nursing service standards  a. Adult Nursing Services for medication oversight are required for all surrogate Living Supports Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living direct support Personnel (including substitute care), if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication.  CHAPTER 12 (SL) 1. Scope of Services A. Living Supports – Supported Living: 20. Assistance in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations, including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and. 2. Service Requirements: L. Training and Requirements: 3. Medication as appropriate; and. 2. Service Requirements: L. Training and Requirements: 3. Medication Assessment and Delivery Policy and Procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards			
individual has regularly scheduled medication.  CHAPTER 12 (SL) 1. Scope of Services A. Living Supports – Supported Living: 20.  Assistance in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations, including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and2. Service Requirements: L.  Training and Requirements: 3. Medication Delivery: Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication Assessment and Delivery Policy and Procedures, New Mexico Nurse	individuals to self-administer medication as appropriate; and  3. Family Living Providers are required to provide Adult Nursing Services and complete the scope of services for nursing assessments and consultation as outlined in the Adult Nursing service standards  a. Adult Nursing Services for medication oversight are required for all surrogate Lining Supports- Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support		
Living Supports – Supported Living: 20.  Assistance in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations, including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and 2. Service Requirements: L. Training and Requirements: 3. Medication Delivery: Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse			
and regulations.	Living Supports – Supported Living: 20. Assistance in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations, including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and2. Service Requirements: L. Training and Requirements: 3. Medication Delivery: Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards		

CHAPTER 15 (ANS) 2. Service Requirements. G. For Individuals Receiving Ongoing

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Tag # 1A27	Standard Level Deficiency		
Incident Mgt. Late and Failure to Report	,		
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS	Based on the Incident Management Bureau's Late and Failure Reports, the Agency did not report suspected abuse, neglect, or exploitation, unexpected and natural/expected deaths; or other reportable incidents to the Division of	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:	Health Improvement, as required by regulations for 2 of 10 individuals.  Individual #3		
A. Duty to report:     (1) All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of	<ul> <li>Incident date 4/20/2015. Allegation was Neglect. Incident report was received on 4/21/2015. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed."</li> </ul>	Desciden	
consumers.  (2) All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety.  B. Reporter requirement. All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident.  C. Initial reports, form of report, immediate	Individual #7  • Incident date 4/20/2015. Allegation was Neglect and Exploitation. Incident report was received on 4/21/2015. Late Reporting. IMB Late and Failure Report indicated incident of Neglect and Exploitation was "Unconfirmed."	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
action and safety planning, evidence preservation, required initial notifications: (1) Abuse, neglect, and exploitation, suspicious injury or death reporting: Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the			

division's hotline to report an allegation of	
abuse, neglect, or exploitation, suspicious	
injury or death directly, or may report through	
the community-based service provider who, in	
addition to calling the hotline, must also utilize	
the division's abuse, neglect, and exploitation	
or report of death form. The abuse, neglect,	
and exploitation or report of death form and	
instructions for its completion and filing are	
available at the division's website,	
http://dhi.health.state.nm.us, or may be	
obtained from the department by calling the	
division's toll free hotline number, 1-800-445-	
6242.	
(2) Use of abuse, neglect, and exploitation	
or report of death form and notification by	
community-based service providers: In	
addition to calling the division's hotline as	
required in Paragraph (2) of Subsection A of	
7.1.14.8 NMAC, the community-based service	
provider shall also report the incident of abuse,	
neglect, exploitation, suspicious injury, or death	
utilizing the division's abuse, neglect, and	
exploitation or report of death form consistent	
with the requirements of the division's abuse,	
neglect, and exploitation reporting guide. The	
community-based service provider shall ensure	
all abuse, neglect, exploitation or death reports	
describing the alleged incident are completed	
on the division's abuse, neglect, and	
exploitation or report of death form and	
received by the division within 24 hours of the	
verbal report. If the provider has internet access, the report form shall be submitted via	
the division's website at	
http://dhi.health.state.nm.us; otherwise it may	
be submitted via fax to 1-800-584-6057. The	
community-based service provider shall ensure	
that the reporter with the most direct	
knowledge of the incident participates in the	
preparation of the report form.	
proparation of the report form.	

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

of the alleged incident of abuse, neglect and

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

Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency		
REQUIREMENTS:  A. General: All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner.  E. Consumer and guardian orientation packet: Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 4 of 10 individuals.  Review of the Agency individual case files revealed the following items were not found and/or incomplete:  • Parent/Guardian Incident Management Training (Abuse, Neglect and Exploitation) (# 2, 7, 8, 10)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →  Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Tag # 1A31	Standard Level Deficiency		
Client Rights/Human Rights	Standard Level Denoising		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].  B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.  C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]  Long Term Services Division Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003	Based on record review and/or interview, the Agency did not ensure the rights of Individuals was not restricted or limited for 2 of 10 Individuals.  No current Human Rights Approval was found for the following:  PRN medication – Ativan for Anxiety. Last Review was dated 3/4/2014. (Individual #7)  Use of baby monitor to monitor for risk of falls. Last Review was dated 3/4/2014. (Individual #10)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →  Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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

Department of Health Developmental	
Disabilities Supports Division (DDSD) -	
Procedure Title:	
Medication Assessment and Delivery	
Procedure Eff Date: November 1, 2006	
<b>3. 1. e.</b> If the PRN medication is to be used in	
esponse to psychiatric and/or behavioral	
symptoms in addition to the above	
requirements, obtain current written consent	
rom the individual, guardian or surrogate	
nealth decision maker and submit for review by	
the agency's Human Rights Committee	
(References: Psychotropic Medication Use	
Policy, Section D, page 5 Use of PRN	
Psychotropic Medications; and, Human Rights	
Committee Requirements Policy, Section B,	
page 4 Interventions Requiring Review and	
Approval – Use of PRN Medications).	
pprovair Coc critical and another.	

Tag # 1A33	Standard Level Deficiency		
Tag # 1A33  Board of Pharmacy – Med. Storage  New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual  E. Medication Storage:  1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee.  2. Drugs to be taken by mouth will be separate from all other dosage forms.  3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature.  4. Separate compartments are required for each resident's medication.	Based on record review and observation, the Agency did not to ensure proper storage of medication for 4 of 7 individuals.  Observation included:  Individual #7  • Fluticasone Prop 50mcg is taken once in each nostril and not kept separate from all other dosage forms.  Individual #8  • Divalproex SOD ER 500mg – a loose pill was found in the individual's medication container. Per New Mexico Board of Pharmacy Model Custodial Drug	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →  Provider: Enter your ongoing Quality Assurance/Quality	
<ol> <li>All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day.</li> </ol>	Procedures Manual. E. Medication Storage: 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist."	Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
<ul> <li>6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist.</li> <li>8. References</li> </ul>	<ul> <li>Individual #9</li> <li>Chloraseptic is taken by mouth and not kept separate from all other dosage forms.</li> <li>Chloraseptic: expired 10/2014. Expired medication was not kept separate from other</li> </ul>		
A. Adequate drug references shall be available for facility staff	medications as required by Board of Pharmacy Procedures.		
H. Controlled Substances (Perpetual Count Requirement)  1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance, indicating the following information:	<ul> <li>Individual #10</li> <li>Chlorhexadrine Rinse 0.12% is taken by mouth and not kept separate from all other dosage forms.</li> </ul>		

a. date	<ul> <li>Neo/poly R/Dev 0.1% cintment is applied to</li> </ul>	
b. time administered	<ul> <li>Neo/poly B/Dex 0.1% ointment is applied to each eye and not kept separate from all</li> </ul>	
c. name of patient	other dosage forms.	
d door	other dosage forms.	
d. dose		
e. practitioner's name		
f. signature of person administering or assisting		
with the administration the dose		
g. balance of controlled substance remaining.		

Tag # LS06 / 6L06	Standard Level Deficiency		
Family Living Requirements	<b>.</b>		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013  CHAPTER 12 (FL) I. Living Supports – Family Living Home Studies: The Living Supports- Family Living Services Provider Agency must complete all Developmental Disabilities Support	Based on record review, the Agency did not complete all DDSD requirements for approval of each direct support provider for 2 of 2 individuals.  Review of the Agency files revealed the following items were not found, incomplete, and/or not current:  • Monthly Consultation with the Direct Support Provider  ° Individual # 1 - None found for 5/2015 - 10/2015.  ° Individual # 6 - None found for 5/2015 - 10/2015.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →  Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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

provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD.		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS D. Scope of DDSD Agreement		
(4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite;		
NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY- BASED SERVICES WAIVER		
ELIGIBLE PROVIDERS:  I. Qualifications for community living service providers: There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards.  (1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.		

Tog # 1 625 / 61 25	Standard Lavel Deficiency		
Tag # LS25 / 6L25	Standard Level Deficiency		
Residential Health and Safety (SL/FL)			
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013	Based on observation, the Agency did not	Provider:	
CHAPTER 11 (FL) Living Supports – Family	ensure that each individuals' residence met all	State your Plan of Correction for the	
	requirements within the standard for 3 of 4	deficiencies cited in this tag here: →	
Living Agency Requirements G. Residence Requirements for Living Supports- Family	Supported Living and Family Living residences.		
Living Services: 1.Family Living Services			
providers must assure that each individual's	Review of the residential records and		
residence is maintained to be clean, safe and	observation of the residence revealed the		
comfortable and accommodates the individuals'	following items were not found, not functioning		
daily living, social and leisure activities. In addition	or incomplete:		
the residence must:			
the residence mass.	Supported Living Requirements:		
j. Maintain basic utilities, i.e., gas, power, water			
and telephone;	Water temperature in home does not exceed		
	safe temperature (110°F)		
k. Provide environmental accommodations and	Water temperature in home measured	Provider:	
assistive technology devices in the residence	114.3 <sup>0</sup> F (#3, 4, 8, 9)	Enter your ongoing Quality Assurance/Quality	
including modifications to the bathroom (i.e.,		Improvement processes as it related to this tag	
shower chairs, grab bars, walk in shower, raised	• Fire extinguisher (#3, 4, 8, 9)	number here: →	
toilets, etc.) based on the unique needs of the			
individual in consultation with the IDT;	Note: The following Individuals share a		
I Have a hattam an anatad an alcotta annala	residence:		
I. Have a battery operated or electric smoke	▶ #3, 4, 8, 9		
detectors, carbon monoxide detectors, fire	▶ #5, 7, 10		
extinguisher, or a sprinkler system;			
m. Have a general-purpose first aid kit;	Family Living Requirements:		
The Trave a general purpose met ala mi,			
n. Allow at a maximum of two (2) individuals to	Accessible written procedures for emergency		
share, with mutual consent, a bedroom and	evacuation e.g. fire and weather-related		
each individual has the right to have his or her	threats (#1, 6)		
own bed;			
	Accessible written procedures for the safe		
o. Have accessible written documentation of	storage of all medications with dispensing		
actual evacuation drills occurring at least three	instructions for each individual that are		
(3) times a year;	consistent with the Assisting with Medication		
	Administration training or each individual's ISP		
p. Have accessible written procedures for the safe	(#1)		
storage of all medications with dispensing			
instructions for each individual that are			

consistent with the Assisting with Medication Delivery training or each individual's ISP; and	<ul> <li>Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes</li> </ul>	
q. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.	the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 6)	
CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports- Supported Living Services: 1. Supported Living Provider Agencies must assure that each individual's residence is maintained to be clean, safe, and comfortable and accommodates the individual's daily living, social, and leisure activities. In addition the residence must:		
f. Maintain basic utilities, i.e., gas, power, water, and telephone;		
g. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;		
h. Ensure water temperature in home does not exceed safe temperature (110°F);		
Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system;		
j. Have a general-purpose First Aid kit;		
k. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and		

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

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

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
		ists to assure that claims are coded and pai	id for in
	odology specified in the approved waiver.		
Tag # 5l44	Standard Level Deficiency		
Adult Habilitation Reimbursement			
Developmental Disabilities (DD) Waiver	Based on record review, the Agency did not	Provider:	
Service Standards effective 4/1/2007	provide written or electronic documentation as	State your Plan of Correction for the	
CHAPTER 1 III. PROVIDER AGENCY	evidence for each unit billed for Adult	deficiencies cited in this tag here: →	
DOCUMENTATION OF SERVICE DELIVERY	Habilitation Services for 1 of 1 individuals.		
AND LOCATION			
A. General: All Provider Agencies shall	Individual #5		
maintain all records necessary to fully	August 2015		
disclose the service, quality, quantity and	<ul> <li>The Agency billed 130 units of Adult</li> </ul>		
clinical necessity furnished to individuals	Habilitation (T2021 U1) from 8/17/2015		
who are currently receiving services. The	through 8/21/2015. Documentation received		
Provider Agency records shall be	accounted for 128 units.		
sufficiently detailed to substantiate the			
date, time, individual name, servicing	<ul> <li>The Agency billed 26 units of Adult</li> </ul>		
Provider Agency, level of services, and	Habilitation (T2021 U1) on 8/31/2015.		
length of a session of service billed.	Documentation received accounted for 24	Provider:	
B. Billable Units: The documentation of the	units.	Enter your ongoing Quality Assurance/Quality	
billable time spent with an individual shall		Improvement processes as it related to this tag	
be kept on the written or electronic record		number here: →	
that is prepared prior to a request for			
reimbursement from the HSD. For each			
unit billed, the record shall contain the			
following:			
(1) Date, start and end time of each service			
encounter or other billable service interval;			
(2) A description of what occurred during the encounter or service interval; and			
(3) The signature or authenticated name of staff providing the service.			
stan providing the service.			
MAD-MR: 03-59 Eff 1/1/2004			
8.314.1 BI RECORD KEEPING AND			
DOCUMENTATION REQUIREMENTS:			
Providers must maintain all records necessary			
to fully disclose the extent of the services			

provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 5 XVI. REIMBURSEMENT A. Billable Unit. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care.		
B. Billable Activities  (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non-face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours.  (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours		

Tag # IS30	Standard Level Deficiency		
Customized Community Supports	-		
Reimbursement			
Developmental Disabilities (DD) Waiver Service	Based on record review, the Agency did not	Provider:	
Standards effective 11/1/2012 revised 4/23/2013	provide written or electronic documentation as	State your Plan of Correction for the	
CHAPTER 6 (CCS) 4. REIMBURSEMENT A.	evidence for each unit billed for Customized	deficiencies cited in this tag here: →	
Required Records: All Provider Agencies	Community Supports for 7 of 7 individuals.		
must maintain all records necessary to fully	1. 2.11.04		
disclose the type, quality, quantity and clinical	Individual #1		
necessity of services furnished to individuals who are currently receiving services. The	August 2015		
Provider Agency records must be sufficiently	<ul> <li>The Agency billed 84 units of Customized Community Supports (group) (T2021 HB</li> </ul>		
detailed to substantiate the date, time,	U8) from 8/10/2015 through 8/14/2015.		
individual name, servicing Provider Agency,	Documentation received accounted for 72		
nature of services, and length of a session of	units.		
service billed.	di ilio.		
	The Agency billed 72 units of Customized		
1. The documentation of the billable time spent	Community Supports (group) (T2021 HB	Provider:	
with an individual shall be kept on the written	U8) from 8/24/2015 through 8/28/2015.	Enter your ongoing Quality Assurance/Quality	
or electronic record that is prepared prior to a	Documentation received accounted for 60	Improvement processes as it related to this tag	
request for reimbursement from the Human	units.	number here: →	
Services Department (HSD). For each unit			
billed, the record shall contain the following:	Individual #2		
a. Date, start and end time of each service	August 2015		
encounter or other billable service interval;	The Agency billed 78 units of Customized     Community Supports (group) (T2021 LIP)		
encounter of other billable service interval,	Community Supports (group) (T2021 HB U7) from 8/17/2015 through 8/21/2015.		
b. A description of what occurred during the	Documentation received accounted for 52		
encounter or service interval; and	units.		
	units.		
c. The signature or authenticated name of staff	The Agency billed 26 units of Customized		
providing the service.	Community Supports (group) (T2021 HB		
	U7) on 8/31/2015. Documentation received		
B. Billable Unit:	accounted for 24 units.		
The billable unit for Individual Customized			
Community Supports is a fifteen (15) minute	Individual #3		
unit.	July 2015		
The billable unit for Community Inclusion	The Agency billed 27 units of Customized		
Aide is a fifteen (15) minute unit.	Community Supports (Individual) (H2021 HB		
(10)	U1) from 7/06/2015 through 7/10/2015.		

- The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group.
- The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Customized Community Supports without prior approval from DDSD.
- 5. The billable unit for Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit. (There is a separate rate established for individuals who require one-to-one (1:1) support either in the community or in a group day setting due to behavioral challenges (NM DDW group G).
- 6. The billable unit for Fiscal Management for Adult Education is dollars charged for each class including a 10% administrative processing fee.

#### C. Billable Activities:

- 1. All DSP activities that are:
- a. Provided face to face with the individual;
- b. Described in the individual's approved ISP;
- c. Provided in accordance with the Scope of Services; and
- d. Activities included in billable services, activities or situations.
- 2. Purchase of tuition, fees, and/or related materials associated with adult education opportunities as related to the ISP Action

Documentation received accounted for 9 units.

#### August 2015

- The Agency billed 66 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/03/2015 through 8/07/2015.
   Documentation received accounted for 32 units.
- The Agency billed 48 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/10/2015 through 8/14/2015.
   Documentation received accounted for 8 units.
- The Agency billed 66 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/17/2015 through 8/21/2015.
   Documentation received accounted for 20 units.
- The Agency billed 32 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/24/2015 through 8/28/2015.
   Documentation received accounted for 4 units.

# September 2015

- The Agency billed 29 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/01/2015 through 9/04/2015.
   Documentation received accounted for 17 units.
- The Agency billed 76 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/14/2015 through 9/18/2015.
   Documentation received accounted for 33 units.

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Plan and Outcomes, not to exceed \$550 including administrative processing fee.

 Customized Community Supports can be included in ISP and budget with any other services.

#### MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:

Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.

#### Individual #4 July 2015

- The Agency billed 37 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/01/2015 through 7/03/2015.
   Documentation received accounted for 18 units.
- The Agency billed 53 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/06/2015 through 7/10/2015.
   Documentation received accounted for 46 units.
- The Agency billed 50 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/13/2015 through 7/17/2015.
   Documentation received accounted for 36 units.
- The Agency billed 41 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/20/2015 through 7/24/2015.
   Documentation received accounted for 27 units.
- The Agency billed 45 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/27/2015 through 7/31/2015.
   Documentation received accounted for 33 units.

# August 2015

- The Agency billed 62 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/03/2015 through 8/07/2015.
   Documentation received accounted for 54 units.
- The Agency billed 50 units of Customized Community Supports (Individual) (H2021 HB

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U1) from 8/17/2015 through 8/21/2015. Documentation received accounted for 40 units.

 The Agency billed 52 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/24/2015 through 8/28/2015.
 Documentation received accounted for 48 units.

#### September 2015

- The Agency billed 36 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/01/2015 through 9/04/2015.
   Documentation received accounted for 28 units.
- The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/08/2015 through 9/11/2015.
   Documentation received accounted for 15 units.
- The Agency billed 63 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/14/2015 through 9/18/2015.
   Documentation received accounted for 46 units.

## Individual #7 July 2015

- The Agency billed 33 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/01/2015 through 7/03/2015.
   Documentation received accounted for 16 units.
- The Agency billed 86 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/06/2015 through 7/10/2015.

Documentation received accounted for 82 units. The Agency billed 42 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/13/2015 through 7/17/2015. Documentation received accounted for 40 units. • The Agency billed 47 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/20/2015 through 7/24/2015. Documentation received accounted for 27 units. August 2015 • The Agency billed 41 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/03/2015 through 8/7/2015. Documentation received accounted for 34 units. The Agency billed 59 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/10/2015 through 8/14/2015. Documentation received accounted for 37 units. • The Agency billed 69 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/24/2015 through 8/28/2015. Documentation received accounted for 45 units. • The Agency billed 12 units of Customized Community Supports (Individual) (H2021 HB U1) on 8/31/2015. No documentation was found on 8/31/2015 to justify the 12 units billed.

Individual #8 July 2015

- The Agency billed 22 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/06/2015 through 7/10/2015.
   Documentation received accounted for 17 units.
- The Agency billed 12 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/13/2015 through 7/17/2015.
   Documentation received accounted for 4 units.
- The Agency billed 60 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/20/2015 through 7/24/2015.
   Documentation received accounted for 36 units.
- The Agency billed 11 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/27/2015 through 7/31/2015. No documentation was found for 7/27/2015 through 7/31/2015 to justify the 11 units billed.

#### August 2015

 The Agency billed 32 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/17/2015 through 8/21/2015.
 Documentation received accounted for 22 units.

# September 2015

- The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/01/2015 through 9/04/2015.
   Documentation received accounted for 24 units.
- The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB

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U1) from 9/14/2015 through 9/18/2015. Documentation received accounted for 12 units.

#### Individual #9 July 2015

- The Agency billed 37 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/01/2015 through 7/03/2015.
   Documentation received accounted for 26 units.
- The Agency billed 32 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/13/2015 through 7/17/2015.
   Documentation received accounted for 28 units.
- The Agency billed 43 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/20/2015 through 7/24/2015.
   Documentation received accounted for 26 units.
- The Agency billed 36 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/27/2015 through 7/31/2015.
   Documentation received accounted for 8 units.

#### August 2015

- The Agency billed 44 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/03/2015 through 8/07/2015.
   Documentation received accounted for 27 units.
- The Agency billed 52 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/10/2015 through 8/14/2015.

Documentation received accounted for 20 units.  • The Agency billed 49 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/17/2015 through 8/21/2015.  Documentation received accounted for 14	
Community Supports (Individual) (H2021 HB U1) from 8/17/2015 through 8/21/2015.	
units.	
September 2015	
The Agency billed 56 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/08/2015 through 9/11/2015. Documentation received accounted for 29 units.	
The Agency billed 63 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/14/2015 through 9/18/2015. Documentation received accounted for 52 units.	

	g # LS26 / 6L26	Standard Level Deficiency		
Su	pported Living Reimbursement			
Der Sta CH A. S ma the ser	velopmental Disabilities (DD) Waiver Service indards effective 11/1/2012 revised 4/23/2013 APTER 12 (SL) 2. REIMBURSEMENT Supported Living Provider Agencies must intain all records necessary to fully disclose type, quality, quantity, and clinical necessity of vices furnished to individuals who are currently eiving services. The Supported Living Services	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 1 of 7 individuals.  Individual #8 July 2015	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
Prodet nar len	ovider Agency records must be sufficiently ailed to substantiate the date, time, individual me, servicing provider, nature of services, and gth of a session of service billed.  The documentation of the billable time spent	<ul> <li>The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/02/2015. No documentation was found on 7/02/2015 to justify the 1 unit billed.</li> <li>The Agency billed 1 unit of Supported Living</li> </ul>		
	with an individual must be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit billed, the record must contain the following:	(T2016 HB U6) on 7/27/2015. No documentation was found on 7/27/2015 to justify the 1 unit billed.  August 2015	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
	Date, start and end time of each service encounter or other billable service interval;  A description of what occurred during the encounter or service interval;	<ul> <li>The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/05/2015. No documentation was found on 8/05/2015 to justify the 1 unit billed.</li> </ul>		
C.	The signature or authenticated name of staff providing the service;	The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/19/2015. No documentation was found on 8/19/2015 to		
d.	The rate for Supported Living is based on categories associated with each individual's NM DDW Group; and	justify the 1 unit billed.		
e.	A non-ambulatory stipend is available for those who meet assessed need requirement.			
	Billable Units: The billable unit for Supported Living is based on a daily rate. A day is determined based on whether the individual was residing in the home at midnight.			

2. The maximum allowable billable units cannot		
exceed three hundred forty (340) calendar		
days per ISP year or one hundred seventy		
(170) calendar days per six (6) months.		
Developmental Disabilities (DD) Waiver Service		
Standards effective 4/1/2007		
CHAPTER 1 III. PROVIDER AGENCY		
DOCUMENTATION OF SERVICE DELIVERY		
AND LOCATION		
A. General: All Provider Agencies shall		
maintain all records necessary to fully		
disclose the service, quality, quantity and		
clinical necessity furnished to individuals		
who are currently receiving services. The		
Provider Agency records shall be sufficiently		
detailed to substantiate the date, time,		
individual name, servicing Provider Agency,		
level of services, and length of a session of		
service billed.		
<b>B. Billable Units:</b> The documentation of the		
billable time spent with an individual shall be		
kept on the written or electronic record that		
is prepared prior to a request for		
reimbursement from the HSD. For each unit		
billed, the record shall contain the following:		
(1) Date, start and end time of each service		
encounter or other billable service interval;		
(2) A description of what occurred during the		
encounter or service interval; and		
(3) The signature or authenticated name of staff		
providing the service.		
MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION		
REQUIREMENTS:		
Providers must maintain all records necessary to		
fully disclose the extent of the services provided		
to the Medicaid recipient. Services that have been		
billed to Medicaid, but are not substantiated in a		
treatment plan and/or patient records for the		
recipient are subject to recoupment.		

Developmental Disabilities (DD) Waiver Service		
Standards effective 4/1/2007		
CHAPTER 6. IX. REIMBURSEMENT FOR		
COMMUNITY LIVING SERVICES		
A. Reimbursement for Supported Living Services		
(1) Billable Unit. The billable Unit for Supported		
Living Services is based on a daily rate. The		
daily rate cannot exceed 340 billable days a		
year.		
(2) Billable Activities		
(a) Direct care provided to an individual in the		
residence any portion of the day.		
(b) Direct support provided to an individual by		
community living direct service staff away		
from the residence, e.g., in the community.		
(c) Any activities in which direct support staff		
provides in accordance with the Scope of		
Services.		
(3) Non-Billable Activities		
(a) The Supported Living Services provider		
shall not bill DD Waiver for Room and Board.		
=		
(b) Personal care, respite, nutritional		
counseling and nursing supports shall not be billed as separate services for an		
individual receiving Supported Living		
Services.		
(c) The provider shall not bill when an		
individual is hospitalized or in an		
institutional care setting.		
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Date: April 21, 2016

To: Hector Johnson, Associate Executive Director

Provider: Community Options, Inc. Address: 2500 Missouri Ave.

State/Zip: Las Cruces, New Mexico 88011

E-mail Address: hector.johnson@comop.org

CC: Robert Stack, Chief Executive Officer

Address: 16 Farber Road

State/Zip: Princeton, New Jersey 08540

E-Mail Address robert.stack@comop.org

Region: Northeast

Survey Date: October 19 – 22, 2015

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: 2012: Living Supports (Supported Living, Family Living); Inclusion Supports

(Customized Community Supports)

2007: Community Living (Supported Living) and Community Inclusion (Adult

Habilitation)

Survey Type: Routine

Dear Mr. Johnson:

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

# Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.

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

After reviewing the documentation submitted through your Plan of Correction, the following items are still outstanding:

#### Tag 1A08.2

- Decision Consultation Forms for the following: (*Please note, documentation provided indicated both individuals were refusing all appointments.*)
  - Individual #1
    - Vision Exam
  - Individual #9
    - Dental Exam
    - Vision Exam



- Cholesterol and Blood Glucose
- Blood Levels

#### Tag 1A09

- Individual #3
  - Polyethylene Glycol 17gm/1 dose powder same dosage
    - Physician Order states "4-8oz 1 time daily, every other day". Medication Administration Record (MAR) provided during the POC process stated "drink daily 4 times a week". However, the MAR was initialed daily, indicating medication was being provided every day.

#### Tag LS25/6L25

- Evidence water temperature in homes do not exceed 110°F (#3, 4, 8, 9). (Please note, "Weekly Water Temperature Check" Log provided during POC process does not specify which homes were checked.)
- Evidence fire extinguishers have been placed in homes (#3, 4, 8, 9). (Please note, only receipt of purchase for extinguishers was provided during POC process.)

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

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

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

Amanda Castañeda

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

Q.16.2.DDW.D3124.2.RTN.07.16.112