Date:	July 15, 2020
To:	Ms. Genevieve Nez Holona, Chief Executive Officer
Provider:	Tohatchi Area of Opportunity Service Inc. (TAOS)
Address:	1658 S. 2nd Street
State/Zip:	Gallup, New Mexico 87301
E-mail Address:	Gen.Holona@taos-inc.org
Region:	Northwest
Routine Survey:	November 27 – December 4, 2019
Verification Survey:	June 22 – July 1, 2020
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Customized Community Supports, and Community Integrated Employment Services
Survey Type:	Verification
Team Leader:	Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Kayla R. Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Bernadette Baca, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Genevieve Nez Holona;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on* November 27 – December 4, *2020*.

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

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

The following tags are identified as Condition of Participation Level:

- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements) **(New / Repeat Findings)**
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up **(New / Repeat Findings)**
- Tag # 1A09 Medication Delivery Routine Medication Administration **(New / Repeat Findings)**

The following tags are identified as Standard Level:

- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements **(New / Repeat Findings)**
- Tag # 1A09.0 Medication Delivery Routine Medication Administration **(New / Repeat Findings)**

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

Plan of Correction:

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

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

Submission of your Plan of Correction:

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

1. **Quality Management Bureau, Attention: Plan of Correction Coordinator**
   5301 Central Ave. NE Suite 400, New Mexico 87108
   MonicaE.Valdez@state.nm.us

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

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

Please contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@state.nm.us if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Lora Norby

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

Survey Process Employed:

Administrative Review Start Date:	June 22, 2020
Contact:	**Tohatchi Area of Opportunity Service Inc. (TAOS)** Genevieve Nez Holona, Chief Executive Director **DOH/DHI/QMB** Lora Norby, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	June 22, 2020
Present:	**Tohatchi Area of Opportunity Service Inc. (TAOS)** Genevieve Nez Holona, Chief Executive Director Melinda Golden, Quality Assurance Manager Tessa Arviso, Service Coordinator **DOH/DHI/QMB** Lora Norby, Team Lead/Healthcare Surveyor
Exit Conference Date:	July 1, 2020
Present:	**Tohatchi Area of Opportunity Service Inc. (TAOS)** Genevieve Nez Holona, Chief Executive Director Melinda Golden, Quality Assurance Manager Janell Chee, Service Coordinator Yolanda Chee, Service Coordinator Melanie Smith, Nurse **DOH/DHI/QMB** Lora Norby, Team Lead/Healthcare Surveyor Kayla R. Benally, BSW, Healthcare Surveyor Bernadette Baca, MPA, Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor **DDSD - Northwest Regional Office** Dennis O'Keefe, Generalist Michele Groblebe, Regional Director
Administrative Locations Visited:	0 *(Note: No administrative locations visited due to COVID-19 Public Health Emergency.)*
Total Sample Size:	5 0 - *Jackson* Class Members 5 - Non-*Jackson* Class Members 5 - Supported Living 5 - Customized Community Supports 2 - Community Integrated Employment
Persons Served Records Reviewed	5
Direct Support Personnel Interviewed during Routine Survey	2

Direct Support Personnel Records Reviewed	28
Service Coordinator Records Reviewed	2
Nurse Interviews completed during Routine Survey	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
    - °Individual Service Plans
    - °Progress on Identified Outcomes
    - °Healthcare Plans
    - °Medication Administration Records
    - °Medical Emergency Response Plans
    - °Therapy Evaluations and Plans
    - °Healthcare Documentation Regarding Appointments and Required Follow-Up
    - °Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

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

Attachment B

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

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Assurance system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

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

Conditions of Participation (CoPs)

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

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

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

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

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

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

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

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

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

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

Service Domain: Health, Welfare and Safety - *The State, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*

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

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

Attachment C

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

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

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Bureau Chief **within 10 business days** of receipt of the final Report of Findings **(*Note: No extensions are granted for the IRF)*.**
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: https://nmhealth.org/about/dhi/cbp/irf/
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Valerie V. Valdez at valerie.valdez@state.nm.us for assistance.

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

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

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

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

Attachment D

QMB Determinations of Compliance

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of *Compliance*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

Partial-Compliance with Standard Level Tags:

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

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

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

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

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety.

Non-Compliance:

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. There are three ways an agency can receive a determination of Non-Compliance:

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

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

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

Agency: **Tohatchi Area of Opportunity Service Inc. (TAOS) – Northwest Region**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Supported Living, Customized Community Supports, and Community Integrated Employment Services
Survey Type: Verification
Routine Survey: **November 27 – December 4, 2019**
Verification Survey: **June 22 – July 1, 2020**

Standard of Care	Routine Survey Deficiencies November 27 – December 4, 2019	Verification Survey New and Repeat Deficiencies June 22 – July 1, 2020
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	**Standard Level Deficiency**	**Standard Level Deficiency**
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents	Based on record review, the Agency did not complete written status reports as required for 4 of 5 individuals receiving Living Care Arrangements and Community Inclusion. **Supported Living Semi-Annual Reports:** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 7/6/2018 – 7/5/2019. Semi-Annual Report 7/2018 – 7/2019; Date Completed: 8/6/2019; ISP meeting held on 3/19/2019).* • Individual #2 - None found for 7/2018 - 1/2019. *(Term of ISP 7/22/2018 – 7/21/2019).* • Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/1/2018 – 3/31/2019. Semi-Annual Report 10/1/2018 – 1/10/19; Date Completed: 1/11/2019; ISP meeting held on 1/10/2019).* **Customized Community Supports Semi-Annual Reports** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 7/6/2018 – 7/5/2019. Semi-Annual Report 7/2018 – 7/2019;*	**New / Repeat Findings:** Based on record review, the Agency did not complete written status reports as required for 1 of 5 individuals receiving Living Care Arrangements and Community Inclusion. **Customized Community Supports Semi-Annual Reports:** • Individual #2 - None found for 7/2019 - 1/2020. *(Term of ISP 7/22/2019 – 7/21/2020).*

of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal	*Date Completed: 8/6/2019; ISP meeting held on 3/19/2019).* • Individual #2 - None found for 7/2018 - 1/2019. *(Term of ISP 7/22/2018 – 7/21/2019).* • Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/1/2018 – 3/31/2019. Semi-Annual Report 10/1/2018 – 1/10/19; Date Completed: 1/11/2019; ISP meeting held on 1/10/2019).* • Individual #5 - None found for 2/2019 – 8/2019. *(Term of ISP 2/8/2019 – 2/7/2020).* **Community Integrated Employment Services Semi-Annual Reports** • Individual #5 - None found for 2/2019 – 8/2019. *(Term of ISP 2/8/2019 – 2/7/2020).* **Nursing Semi-Annual:** • Individual #1 - None found for 7/2018 – 1/2019. *(Term of ISP 7/6/2018 - 7/5/2019. ISP meeting held on 3/19/2019).* • Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/1/2018 – 3/31/2019. ISP meeting held on 1/10/2019) Semi-Annual Report 12/1/2017 – 12/19/2018; Date Completed: 5/17/2019; ISP meeting held on 1/10/2019). (Per regulations reports must coincide with ISP term).* • Individual #5 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 2/8/2018 – 2/7/2019. Semi-Annual Report 2/8/2018 – 10/23/2018; Date Completed: 10/31/2018; ISP meeting held on 11/8/2018).*	

from services. **Chapter 19: Provider Reporting Requirements** **19.5 Semi-Annual Reporting:** The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDSD for QA activities. Semi-annual reports are required as follows: 1. DD Waiver Provider Agencies, except AT, EMSP, Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports. 2. A Respite Provider Agency must submit a semi-annual progress report to the CM that describes progress on the Action Plan(s) and Desired Outcome(s) when Respite is the only service included in the ISP other than Case Management, for an adult age 21 or older. 3. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days). 4. The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting. 5. Semi-annual reports must contain at a minimum written documentation of: a. the name of the person and date on each page; b. the timeframe that the report covers; c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering; d. a description of progress towards Desired Outcomes in the ISP related to the service provided;		

e. a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing); f. significant changes in routine or staffing if applicable; g. unusual or significant life events, including significant change of health or behavioral health condition; h. the signature of the agency staff responsible for preparing the report; and i. any other required elements by service type that are detailed in these standards.		

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	Condition of Participation Level Deficiency	Condition of Participation Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 3 of 5 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Teaching and Support Strategies:** ***Individual #3:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "Research recipes." *TSS not found for the following Live Outcome Statement / Action Steps:* • "Choose and purchase ingredients." *TSS not found for the following Live Outcome Statement / Action Steps:* • "…will independently prepare meal." **Health Care Plans:** • Seizures (#5) **Medical Emergency Response Plans:** • Diabetes (#3) • Musculoskeletal (#2) • Neuro (Devices and Implants) (#2)	**New / Repeat Findings:** After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 3 of 5 Individuals receiving Living Care Arrangements. Per the Agency's Plan of Correction approved on 4/27/2020 the Agency stated " a. ISCs and Health Department will write a T-Log in Therap when any new document is placed in the residential/master binder for tracking purposes; b. ISCs and Health Department will log in the master binder on the Access Log when updating files in the binder; c. Tracking documents will affect 18 DDW individuals." No evidence of required documents placed in the residential binder per monthly tracking was provided during the Verification Survey completed June 22 – July 1, 2020 for the following: **ISP Teaching and Support Strategies:** ***Individual #3:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "…will create lists." **Health Care Plans:** • Seizures (#5) **Medical Emergency Response Plans:** • Diabetes (#3) • Neuro (Devices and Implants) (#2)

services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. Requirements for the *Health Passport* and *Physician Consultation* form are: 2. The Primary and Secondary Provider Agencies must ensure that a current copy of the *Health Passport* and *Physician Consultation* forms are printed and available at all service delivery sites. Both forms must be reprinted and placed at all service delivery sites each time the e-CHAT is updated for any reason and whenever there is a change to contact information contained in the IDF. **Chapter 13: Nursing Services: 13.2.9 Healthcare Plans (HCP)*:*** 1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed		

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

Standard of Care	Routine Survey Deficiencies November 27 – December 4, 2019	Verification Survey New and Repeat Deficiencies June 22 – July 1, 2020
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Condition of Participation Level Deficiency**	**Condition of Participation Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 3 Safeguards: 3.1.1 *Decision Consultation Process (DCP):*** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: 1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and d. recommendations made through a Healthcare	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 1 of 5 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):*** **Annual Physical:** • Individual #5 - As indicated by collateral documentation reviewed, exam was completed on 5/22/2019. Follow-up was to be completed in 6 months. No evidence of follow-up found. **Dental Exam:** • Individual #5 - As indicated by collateral documentation reviewed, exam was completed on 5/1/2019. Follow-up was to be completed 10/19/2019. No evidence of follow-up found.	**New / Repeat Findings:** After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 1 of 5 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):*** **Dental Exam:** • Individual #5 - As indicated by collateral documentation reviewed, the Dental Exam was not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)*

Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:		

1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 *Health Passport and Physician Consultation Form:*** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact		

information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. **Chapter 10: Living Care Arrangements (LCA) Living Supports-Supported Living: 10.3.9.6.1 Monitoring and Supervision** 4. Ensure and document the following: a. The person has a Primary Care Practitioner. b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist. c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist. d. The person receives a hearing test as recommended by a licensed audiologist. e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist. 5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine). **10.3.10.1 Living Care Arrangements (LCA) Living Supports-IMLS: 10.3.10.2 General Requirements:** 9. Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and annual dental checkup by a licensed dentist).		

Chapter 13 Nursing Services: 13.2.3 General Requirements: 1. Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information.		

Tag # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency	Condition of Participation Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments;	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of 11/2019 and 12/2019. Based on record review, 4 of 5 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #2 November 2019 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Lorazepam 1 mg (3 times daily) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Olopatadine HCL 0.1% drops (2 times daily) • Divalproex 500 mg (2 times daily) • Levetiracetam F/C 750 mg (2 times daily) Individual #3 November 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Apple Cider Vinegar 15 cc (1 time daily) – Blank 11/27 (8:00 pm) • Doxycycline Hyclate FC 100 mg (2 times daily) – Blank 11/27 (8:00 pm)	**New / Repeat Findings:** After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the month of May 2020. Based on record review, 1 of 5 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #5 May 2020 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Valproic Acid 250 mg (3 capsules 1 time daily) – Blank 5/6 (8:00 pm)

d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training; 2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication	• Neutrogena Body Clear Bodywash 7 ml (1 time daily) – Blank 11/27 (8:00 pm) • Simvastatin F/C 10 mg (1 time daily) – Blank 11/27 (8:00 pm) • Tea Tree Oil paint small amount on toenails (1 time daily) – Blank 11/27 (8:00 pm) • Triamcinolone Acetonide .1% cream (2 times daily) – Blank 11/27 (8:00 pm) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Apple Cider Vinegar 15 cc (1 time daily) • Neutrogena Body Clear Bodywash 7 ml (1 time daily) • Simvastatin F/C 10 mg (1 time daily) • Tea Tree Oil paint small amount on toenails (1 time daily) Individual #4 November 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Atorvastatin 40 mg (1 time daily) – Blank 11/27 (8:00 pm) • Losartan Potas 100 mg (1 time daily) – Blank 11/27 (8:00 pm) • Metformin HCl FC 500 mg 1/2 tablet (1 time daily) – Blank 11/27 (5:00 pm)	

Administration Record (MAR). **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24-hour period.	Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Moisturizing Cream (2 times daily) Individual #5 November 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Calcium Carbonate 600 mg (1 time daily) – Blank 11/28 - 30 (8:00 am) • Daily Vit tablet (1 time daily) – Blank 11/28 - 30 (8:00 am) • Valproic Acid 250 mg (2 capsules 1 time daily) – Blank 11/28 - 30 (8:00 am) • Valproic Acid 250 mg (3 capsules 1 time daily) – Blank 11/27 - 30 (8:00 pm) December 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Calcium Carbonate 600 mg (1 time daily) – Blank 12/1 (8:00 am) • Daily Vit tablet (1 time daily) – Blank 12/1 (8:00 am) • Valproic Acid 250 mg (1 time daily) – Blank 12/1 (8:00 am)	

Tag # 1A09.0 Medication Delivery Routine Medication Administration	Standard Level Deficiency	Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 8. Including the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments;	Medication Administration Records (MAR) were reviewed for the months of 11/2019 and 12/2019. Based on record review, 3 of 5 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #1 November 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Flovent HFA 44 mcg Inhaler (2 times daily) Medication Administration Records did not contain the correct diagnosis for which the medication is prescribed: • Divalproex Sodium DR 250 mg (2 times daily). *MAR indicated medication was to be given for Profound Intellectual Disability. Physician orders indicated medication was to be given for Seizures.* • Divalproex Sodium DR 500 mg (2 times daily). *MAR indicated medication was to be given for Mental Health. Physician orders indicated medication was to be given for Seizures.* Individual #2 November 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Docusate Sodium 100 mg (2 times daily) • Lamotrigine 100 mg (2 times daily)	**New / Repeat Findings** Medication Administration Records (MAR) were reviewed for the month of May 2020. Based on record review, 2 of 5 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #1 May 2020 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Divalproex 250 mg (2 times daily) • Divalproex 500 mg (2 times daily) • Clotrimazole 1% Topical Cream (2 x daily) Individual #2 May 2020 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Lamotrigine 100 mg (2 times daily)

d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training; 2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication	• Lamotrigine 25 mg (2 times daily) Individual #5 November 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Calcium Carbonate 600 mg (1 time daily) Medication Administration Records did not contain the route of administration for the following medications: • Valproic Acid 250 mg (2 capsules 1 time daily) • Valproic Acid 250 mg (3 capsules 1 time daily)	

Administration Record (MAR). **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24-hour period.		

Standard of Care	Routine Survey Deficiencies November 27 – December 4, 2019	Verification Survey New and Repeat Deficiencies June 22 – July 1, 2020
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	**Standard Level Deficiency**	**Complete**
Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	**Condition of Participation Level Deficiency**	**Complete**
Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	**Standard Level Deficiency**	**Complete**
Tag # 1A38.1 Living Care Arrangement / Community Inclusion Reporting Requirements (Reporting Components)	**Standard Level Deficiency**	**Complete**
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A20 Direct Support Personnel Training	**Standard Level Deficiency**	**Complete**
Tag # 1A22 Agency Personnel Competency	**Condition of Participation Level Deficiency**	**Complete**
Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	**Standard Level Deficiency**	**Complete**
Tag # 1A37 Individual Specific Training	**Standard Level Deficiency**	**Complete**
Tag # 1A43.1 General Events Reporting: Individual Reporting	**Standard Level Deficiency**	**Complete**
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)	**Standard Level Deficiency**	**Complete**
Tag # 1A09.1 Medication Delivery PRN Medication Administration	**Condition of Participation Level Deficiency**	**Complete**
Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	**Standard Level Deficiency**	**Complete**
Tag # 1A15 Healthcare Coordination - Nurse Availability / Knowledge	**Condition of Participation Level Deficiency**	**Complete**
Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	**Condition of Participation Level Deficiency**	**Complete**

Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	**Standard Level Deficiency**	**Complete**
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*		
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**	**Complete**

	Verification Survey Plan of Correction, On-going QA/QI and Responsible Party	Completion Due
Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # 1A09 Medication Delivery Routine Medication Administration	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A09.0 Medication Delivery Routine Medication Administration	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date:	August 12, 2020
To:	Ms. Genevieve Nez-Holona, Chief Executive Officer
Provider:	Tohatchi Area of Opportunity Service Inc. (TAOS)
Address:	1658 S. 2nd Street
State/Zip:	Gallup, New Mexico 87301
E-mail Address:	Gen.Holona@taos-inc.org
Region:	Northwest
Routine Survey:	November 27 – December 4, 2019
Verification Survey:	June 22 – July 1, 2020
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Customized Community Supports, and Community Integrated Employment Services
Survey Type:	Verification

Dear Ms. Nez-Holona and Ms. Golden:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Monica Valdez, BS

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

Q.20.4.DDW.D1703.1.VER.09.20.225