NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date:	July 17, 2023
To:	Michael Buszek, Ph.D., President / Executive Director
Provider: Address: State/Zip:	Transitional Lifestyles Community, LLC 8500 Menaul Blvd NE, A200 Albuquerque, New Mexico 87112
E-mail Address:	tranlifellc@outlook.com
Region: Survey Date:	Metro June 5 – 15, 2023
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living and Family Living
Survey Type:	Routine
Team Leader:	Kayla R. Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Kathryn Conticelli, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Nicole Devoti, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Alyssa Swisher, RN, QMB Nurse Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Michael Buszek, Ph.D;

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:

Non-Compliance: This determination is based on noncompliance with 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 or any amount of Standard Level Tags with 6 or more 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 # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components
- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation
- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # 1A20 Direct Support Professional Training
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A25.1 Caregiver Criminal History Screening
- Tag # 1A26.1 Employee Abuse Registry
- Tag # 1A37 Individual Specific Training
- Tag #1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A09 Medication Delivery Routine Medication Administration
- Tag # 1A09.1 Medication Delivery PRN Medication Administration
- Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication
- Tag # 1A15 Healthcare Coordination - Nurse Availability / Knowledge
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)
- Tag # 1A31 Client Rights / Human Rights

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File (Other Required Documents)
- Tag # 1A08.1 Administrative and Residential Case File: Progress Notes
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)
- Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)
- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements
- Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)
- Tag #1A25 Caregiver Criminal History Screening
- Tag # 1A26 Employee Abuse Registry
- Tag # 1A43.1 General Events Reporting: Individual Reporting
- Tag # 1A03 Quality Improvement System & Key Performance Indicators (KPIs)
- Tag # 1A09.0 Medication Delivery Routine Medication Administration
- Tag # 1A09.1.0 Medication Delivery PRN Medication Administration
- Tag # 1A29 Complaints / Grievances Acknowledgement
- Tag # 1A33.1 Board of Pharmacy – License
- Tag # LS06 Family Living Requirements
- Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)
- Tag # LS26 Supported Living Reimbursement
- Tag # LS27 Family Living Reimbursement

Plan of Correction:

The attached Report of Findings identifies the deficiencies found during your agency's on-site 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.

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (Attachment A) for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

Corrective Action for Current Citation:

- How is the deficiency going to be corrected? (i.e. obtained documents, retrain staff, individuals and/or staff no longer in service, void/adjusts completed, etc.) This can be specific to each deficiency cited or if possible an overall correction, i.e. all documents will be requested and filed as appropriate.

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done on an ongoing basis? (i.e. file reviews, etc.)

- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position within your agency)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

Submission of your Plan of Correction:
Please submit your agency's Plan of Correction in the available space on the two right-hand 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, Monica Valdez, Plan of Correction Coordinator** at MonicaE.Valdez@doh.nm.gov

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" claim 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: *Lisa Medina-Lujan*
HSD/OIG/Program Integrity Unit
PO Box 2348
1474 Rodeo Road
Santa Fe, New Mexico 87505

If you have questions and would like to speak with someone at HSD/OIG/PIU, please contact:

Lisa Medina-Lujan (Lisa.medina-lujan@hsd.nm.gov)

Please be advised that there is a one-week lag period for applying payments received by check to Void/Adjust 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:

ATTN: QMB Bureau Chief
Request for Informal Reconsideration of Findings
5300 Homestead Rd NE, Suite 300-3223

Albuquerque, NM 87110
Attention: IRF request/QMB

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 contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@doh.nm.gov 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,

Kayla R. Benally, BSW

Kayla R. Benally, BSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	June 5, 2023
Contact:	**Transitional Lifestyles Community, LLC** Nathan Buszek, Service Coordinator **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead/Healthcare Surveyor
On-Site Entrance Conference Date:	*Entrance Conference was waived by provider.*
Exit Conference Date:	June 15, 2023
Present:	**Transitional Lifestyles Community, LLC** Nathan Buszek, Service Coordinator Mark Mondragon, Supported Living Coordinator Danette Danzer, Registered Nurse Nancy Molisee, Chief Financial Officer **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead/Healthcare Surveyor Kathryn Conticelli, Healthcare Surveyor Nicole Devoti, BA, Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Valerie V. Valdez, MS, QMB Bureau Chief
Administrative Locations Visited:	1 (8500 Menaul Blvd NE A200 Albuquerque, New Mexico 87112)
Total Sample Size:	11 0 - *Former Jackson Class Members* 11 - Non-*Jackson* Class Members 4 - Supported Living 7 - Family Living
Total Homes Visited	9
❖ Supported Living Homes Visited	2 *Note: The following Individuals share a SL residence:* • #1, 4 • #2, 11
❖ Family Living Homes Visited	7
Persons Served Records Reviewed	11
Persons Served Interviewed	8
Persons Served Observed	3 *(Note: Three Individuals chose not to participate in the interview process)*
Direct Support Professional Records Reviewed	35
Direct Support Professional Interviewed	9

Substitute Care/Respite Personnel Records Reviewed	10
Service Coordinator Records Reviewed	2
Administrative Interview	1
Nurse Interview	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
    - °Medical Emergency Response Plans
    - °Medication Administration Records
    - °Physician Orders
    - °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
- Quality Assurance / Improvement Plan

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

Attachment 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 DDSD Regional Office for purposes of contract management or 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 505-273-1930 or email at MonicaE.Valdez@doh.nm.gov. 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 cited to prevent recurrence and information that ensures the regulation cited comes into and remains in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance (QA) Plan.

If a deficiency has already been corrected since the on-site survey, 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 following details should be considered when developing your Plan of Correction:

The Plan of Correction must address each deficiency cited in the Report of Findings unless otherwise noted with a "No Plan of Correction Required statement." The Plan of Correction must address the five (5) areas listed below:

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 those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented, and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and

5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

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

- Details about how and when Individual Served, agency personnel and administrative and service delivery site 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 to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (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, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@doh.nm.gov for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Monica Valdez, POC Coordinator via email at MonicaE.valdez@doh.nm.gov. Please also submit your POC to your Developmental Disabilities Supports Division Regional Office for region of service surveyed.
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. You must also submit evidence of the ongoing Quality Assurance/Quality Improvement processes.

1. Your internal documents are due within a *maximum* of 45-business days of receipt of your Report of Findings.
2. Please submit your documents electronically according to the following: If documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to the State email account. If documents contain PHI **do not** submit PHI directly to the State email account. *You may submit PHI **only** when **replying** to a **secure** email received from the State email account*. When possible, please submit requested documentation using a "zipped/compressed" file to reduce file size. You may also submit documents via S-Comm (Therap), or another electronic format, i.e., flash drive.
3. All submitted documents *must be annotated*; 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.

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 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 Professional 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@doh.nm.gov 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.					

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08 Administrative Case File (Other Required Documents)	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 20: Provider Documentation and Client Records: 20.1 HIPAA:** DD Waiver Provider Agencies shall comply with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH). All DD Waiver Provider Agencies are required to store information and have adequate procedures for maintaining the privacy and the security of individually identifiable health information. HIPPA compliance extends to electronic and virtual platforms. **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	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 11 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Positive Behavioral Support Plan:** • Not Found (#7) • Not Current (#11) **Behavior Crisis Intervention Plan:** • Not Current (#11) **Occupational Therapy Plan (Therapy Intervention Plan TIP):** • Not Found (#6) **Physical Therapy Plan (Therapy Intervention Plan TIP)**: • Not Found (#6)	**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?)***:** →	

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 are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.			

Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **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 are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all 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	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 2 of 11 Individuals. Review of the Agency individual case files revealed the following items were not found: **Administrative Case File:** **Supported Living Progress Notes/Daily Contact Logs:** • Individual #2 - None found for 2/28/2023. **Residential Case File:** **Supported Living Progress Notes/Daily Contact Logs:** • Individual #2 - None found for 6/3 – 5, 2023. *(Date of home visit: 6/6/2023)* **Family Living Progress Notes/Daily Contact Logs:** • Individual #10 - None found for 6/1 – 6, 2023. *(Date of home visit: 6/7/2023)*	**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?)*: →	

documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A: Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.			

Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	Condition of Participation Level Deficiency		
NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY. **NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS.** **NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.** Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 6 Individual Service Plan (ISP)** The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP. **6.6 DDSD ISP Template:** The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e., an acknowledgement of receipt of specific information) and other elements depending on the age and status of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use to better demonstrate required elements of the PCP process and ISP development. **6.6.1 Vision Statements: The long-term vision statement describes the person's major long-term (e.g., within one to three**	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 at the administrative office for 2 of 11 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Teaching and Support Strategies:** ***Individual #1:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • … will complete his oral care with minimal support. ***Individual #2:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • … will research and discuss meal choice view and discuss appointments with staff and/or medical providers.	**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?)*: →	

years) life dreams and aspirations in the following areas: 1. Live, 2. Work/Education/Volunteer, 3. Develop Relationships/Have Fun, and 4. Health and/or Other (Optional). **6.6.2 Desired Outcomes:** A Desired Outcome is required for each life area (Live, Work, Fun) for which the person receives paid supports through the DD Waiver. Each service does not need its own, separate outcome, but should be connected to at least one Desired Outcome. **6.6.3.1 Action Plan:** Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes. **6.6.3.2 Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI):** After the ISP meeting, IDT members conduct a task analysis and assessments necessary to create effective TSS and WDSI to support those Action Plans that require this extra detail. **6.6.3.3 Individual Specific Training in the ISP:** The CM, with input from each DD Waiver Provider Agency at the annual ISP meeting, completes the IST requirements section of the ISP form listing all training needs specific to the individual. **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.			

Tag # 1A32 Administrative Case File: 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 play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 5 of 11 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Live area. **Agency's Outcomes/Action Steps are as follows:** ◦ *"… will complete his own personal hygiene."* **Annual ISP (11/2022 – 11/2023) Outcomes/Action Steps are as follows:** ◦ *"… will complete his oral care with minimal support."* Individual #2 • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Live area. **Agency's Outcomes/Action Steps are as follows:**	**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?)*: →	

developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 6 Individual Service Plan (ISP): 6.9** ISP Implementation and Monitoring All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Section II Chapter 20: Provider Documentation and Client Records) CMs facilitate and maintain communication with the person, their guardian, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of their services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Section II Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. 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.	◦ *"… will research/discuss meal choice."* **Annual ISP (12/2022 – 11/2023) Outcomes/Action Steps are as follows:** ◦ *"… will research and discuss meal choice view and discuss appointments with staff and/or medical providers."* Individual #11 • None found regarding: Live Outcome/Action Step: "… will not elope and he will practice the safety skill" for 4/2023. Action step is to be completed 3 times per week. **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #8 • None found regarding: Live Outcome/Action Step: "… will practice making new recipes" for 2/2023 – 3/2023. Action step is to be completed 2 times per month. *Note: Document maintained by the provider was blank.* • None found regarding: Live Outcome/Action Step: "With assistance, … will prepare a new recipe" for 2/2023 – 3/2023. Action step is to be completed 1 time per month. *Note: Document maintained by the provider was blank.* • None found regarding: Health Outcome/Action Step: "… will exercise for 30 minutes" for 2/2023 – 3/2023. Action step is to be completed 3 times per week. *Note: Document maintained by the provider was blank.* Individual #10 • Review of Agency's documented Outcomes and Action Steps do not match the current		

	ISP Outcomes and Action Steps for Live area. **Agency's Outcomes/Action Steps are as follows:** ◦ *"During the months of July, August, September and October, I will harvest and use the fruits/vegetables and/or flowers as they ripen."* **Annual ISP (11/2022 – 11/2023) Outcomes/Action Steps are as follows:** ◦ *"During the months of March and April two times a week, I will work the soil preparing for planting in the garden."*		

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and	Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 2 of 11 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Family Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes:** Individual #3 • According to the Live Outcome; Action Step for "With 0-2 prompts … will gather and separate laundry" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/2023. Individual #6 • According to the Live Outcome; Action Step for "… will sort his clothes" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2023 – 4/2023.	**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?)***:** →	

purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 6 Individual Service Plan (ISP): 6.9** ISP Implementation and Monitoring All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Section II Chapter 20: Provider Documentation and Client Records) CMs facilitate and maintain communication with the person, their guardian, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of their services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Section II Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. 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.			

Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and	Based on residential record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 11 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking / Progress with regards to ISP Outcomes**: Individual #1 • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Live **Agency's Outcomes/Action Steps are as follows:** ◦ *"… will complete his own personal hygiene with minimal assistance."* **Annual ISP (11/2022 – 11/2023) Outcomes/Action Steps are as follows:** ◦ *"… will complete his oral care with minimal support."*	**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?)*: →	

purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 6 Individual Service Plan (ISP): 6.9** ISP Implementation and Monitoring All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Section II Chapter 20: Provider Documentation and Client Records) CMs facilitate and maintain communication with the person, their guardian, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of their services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Section II Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and			

essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all 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.			

Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	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 Waiver Service Standards Eff 11/1/2021 **Chapter 19 Provider Reporting Requirements: 19.5 Se**mi-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, PRSC, SSE and Crisis Supports, must complete semi-annual.	Based on record review, the Agency did not complete written status reports as required for 2 of 11 individuals receiving Living Care Arrangements and Community Inclusion. **Supported Living Semi-Annual Reports:** • Individual #1 - None found for 11/2022 – 5/2023. *(Term of ISP 11/2022 – 11/2023).* **Family Living Semi- Annual Reports:** • Individual #6 – None found for 9/2022 – 2/2023. *(Term of ISP 9/2022 – 8/2023).* **Nursing Semi-Annual:** • Individual #1 – None found for 11/2022 – 5/2023. *(Term of ISP 11/2022 – 11/2023).*	**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?)*: →	

2. 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). 3. 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. 4. 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. 5. Semi-annual reports must be distributed to the IDT members when due by SComm. 6. Semi-annual reports can be stored in individual document storage. **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 are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all 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 details the minimum			

requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.			

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 6 Individual Service Plan (ISP)** The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP. **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 are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 7 of 11 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **Annual ISP:** • Not Current (#1, 4) **ISP Teaching and Support Strategies:** ***Individual #1:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • … will complete his oral care with minimal support. *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:* • … will plan and visit with his family. • … will schedule and attend his own medical appts. ***Individual #4:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • … will complete the task around the house that need to be done. ***Individual #5:***	**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?)***:** →	

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. **20.5.4 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form generated from an e-CHAT in 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.	*TSS not found for the following Live Outcome Statement / Action Steps:* • … will take photos using her phone on her camera. • … will save her best photos to a laptop. **Healthcare Passport:** • Not Found (#6, 9) • Not Current (#2) **Health Care Plans:** • BMI (#1) • Bowel and Bladder (#1, 4) • Constipation (#1) • Diabetes (#2) • Fluid Restriction (#4) • Hydration (#1) • Intake Monitoring (#2) • Paralysis (#1) • Respiratory (#2) • Skin and Wound (#1) • Spasticity and Contractures (#1) • Status of Care/Hygiene (#5) **Medical Emergency Response Plans:** • Allergies (#11) • Aspiration (#1, 4, 11) • Endocrine (Diabetes) (#4, 5) • Constipation (#11) • Gastrointestinal – Abdominal Pain (#2) • Hypertension (#4) • Paralysis (#1) • Respiratory (#2) • Risk of Falls (#4)		

Chapter 13 Nursing Services: 13.2.9.1 Health Care Plans (HCP): Health Care Plans are created to provide guidance for the Direct Support Professionals (DSP) to support health related issues. Approaches that are specific to nurses may also be incorporated into the HCP. Healthcare Plans are based upon the eCHAT and the nursing assessment of the individual's needs. **13.2.9.2 Medical Emergency Response Plan (MERP): 1)** The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions automatically triggered and marked with an "R" in the e-CHAT summary report. The agency nurse should use their clinical judgment and input from. 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.			

Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)	Standard Level Deficiency		
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 are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all 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	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 4 of 11 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **Positive Behavioral Supports Plan:** • Not Found (#2, 3, 7) • Not Current (#11) **Behavior Crisis Intervention Plan:** • Not Found (#11)	**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?)*: →	

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.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
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 Professional Training	**Condition of Participation Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 17 Training Requirements: 17.1 Training Requirements for Direct Support Professional and Direct Support Supervisors:** Direct Support Professional (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports. 1. DSP/DSS must successfully complete within 30 calendar days of hire and prior to working alone with a person in service: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in Chapter 17.9 Individual Specific Training below. b. Complete DDSD training in standards precautions located in the New Mexico Waiver Training Hub. c. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. d. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). e. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, Crisis Prevention and Intervention (CPI)) before using Emergency Physical Restraint (EPR). Agency DSP and DSS shall maintain certification in a DDSD-approved system if any person they	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not ensure Orientation and Training requirements were met for 24 of 37 Direct Support Professional, Direct Support Supervisory Personnel and / or Service Coordinators. Review of Agency training records found no evidence of the following required DOH/DDSD trainings being completed: **First Aid:** • Not Found (#500, 501, 504, 505, 506, 507, 509, 511, 515, 516, 517, 518, 519, 522, 523, 525, 526, 527, 530, 532, 533, 534, 546) **CPR:** • Not Found (#500, 501, 504, 505, 506, 507, 509, 511, 515, 516, 517, 518, 519, 522, 523, 525, 526, 527, 530, 532, 533, 534, 546) **Assisting with Medication Delivery:** • Not Found (#500, 501, 504, 505, 511, 515, 522) • Expired (#545)	**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?)*: →	

support has a BCIP that includes the use of EPR. f. Complete and maintain certification in a DDSD-approved Assistance with Medication Delivery (AWMD) course if required to assist with medication delivery. g. Complete DDSD training regarding the HIPAA located in the New Mexico Waiver Training Hub. **17.1.13 Training Requirements for Service Coordinators (SC):** Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports. 1. A SC must successfully complete within 30 calendar days of hire and prior to working alone with a person in service: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported, and as outlined in the Chapter 17.10 Individual-Specific Training below. b. Complete DDSD training in standard precautions located in the New Mexico Waiver Training Hub. c. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. d. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). e. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using emergency physical restraint. Agency SC shall maintain certification in a DDSD-			

approved system if a person they support has a Behavioral Crisis Intervention Plan that includes the use of emergency physical restraint. f. Complete and maintain certification in AWMD if required to assist with medications. g. Complete DDSD training regarding HIPAA located in the New Mexico Waiver Training Hub.			

Tag # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 17 Training Requirements** **17.9 Individual-Specific Training Requirements:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. The trainer must observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 2 of 9 Direct Support Professional. **When DSP were asked, if the Individual had Positive Behavioral Supports Plan (PBSP), If they had been trained on the PBSP and what does the plan cover, the following was reported:** • DSP #519 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #1) • DSP #519 stated, "He doesn't have a plan but we will work with him on side hugging and pushing people away." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #4) **When DSP were asked, if the Individual's had Health Care Plans, where could they be located and if they had been trained, the following was reported:** • DSP #519 stated, "Prediabetes." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires Health Care Plans for Bowel/Bladder Function, Fluid Restriction, Intake/Output Monitoring, Respiratory and the Individual Specific Training section of the ISP indicates the Individual requires Health Care Plans for COPD and Hypertension (Individual #4)	**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?)*: →	

requirements in accordance with the specifications described in the ISP of each person supported. 1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, Teaching and Support Strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends. 2. IST for therapy-related Written Direct Support Instructions (WDSI), Healthcare Plans (HCPs), Medical Emergency Response Plan (MERPs), Comprehensive Aspiration Risk Management Plans (CARMPs), Positive Behavior Supports Assessment (PBSA), Positive Behavior Supports Plans (PBSPs), and Behavior Crisis Intervention Plans (BCIPs), PRN Psychotropic Medication Plans (PPMPs), and Risk Management Plans (RMPs) must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds problems with implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher. 3. The competency level of the training is based on the IST section of the ISP. 4. The person should be present for and involved in IST whenever possible. 5. Provider Agencies are responsible for tracking of IST requirements. 6. Provider Agencies must arrange and ensure that DSP's and CIE's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings.	**When DSP were asked, if the Individual had Medical Emergency Response Plans where could they be located and if they had been trained, the following was reported, the following was reported:** • DSP #519 stated, "Prediabetes, General health, Oxygen Therapy, Aspiration, Falls and Fractures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires Medical Emergency Response Plans for Hypertension and Hypernatremia. (Individual #4) • DSP #516 stated, "Yes, Seizures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires Medical Emergency Response Plans for Aspiration and Constipation (Individual #11)		

7. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan.			

Tag #1A25 Caregiver Criminal History Screening	Standard Level Deficiency		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **A. General:** The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (Amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider] to impose appropriate administrative sanctions and penalties. **B. Exception:** A caregiver or hospital caregiver applying for employment or contracting services with a care provider within twelve (12) months of the caregiver's or hospital caregiver's most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested. **C. Conditional Employment:** Applicants, caregivers, and hospital caregivers who have	Based on record review, the Agency did not maintain documentation indicating Caregiver Criminal History Screening was completed as required for 1 of 47 Agency Personnel. **The following Agency Personnel Files contained Caregiver Criminal History Screenings, which were not specific to the current term of employment:** **Direct Support Professional (DSP):** • #516 – Date of hire 12/25/2021.	**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?)*: →	

submitted all completed documents and paid all applicable fees for a nationwide and statewide criminal history screening may be deemed to have conditional supervised employment pending receipt of written notice given by the department as to whether the applicant, caregiver or hospital caregiver has a disqualifying conviction. **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **G. Maintenance of Records:** Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:**			

A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.			

Tag # 1A25.1 Caregiver Criminal History Screening	Condition of Participation Level Deficiency		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **A. General:** The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (Amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider] to impose appropriate administrative sanctions and penalties. **B. Exception:** A caregiver or hospital caregiver applying for employment or contracting services with a care provider within twelve (12) months of the caregiver's or hospital caregiver's most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested. **C. Conditional Employment:** Applicants, caregivers, and hospital caregivers who have	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 documentation indicating Caregiver Criminal History Screening was completed as required for 1 of 47 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Substitute Care/Respite Personnel:** • #536 – Date of hire 3/15/2023.	**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?)*: →	

submitted all completed documents and paid all applicable fees for a nationwide and statewide criminal history screening may be deemed to have conditional supervised employment pending receipt of written notice given by the department as to whether the applicant, caregiver or hospital caregiver has a disqualifying conviction. **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **G. Maintenance of Records:** Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND**			

APPLICANTS WITH DISQUALIFYING CONVICTIONS: **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.			

Tag # 1A26 Employee Abuse Registry	Standard Level Deficiency		
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 4 of 47 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Professional (DSP):** • #501 – Date of hire 1/18/2018, completed 2/2/2018. • #507 – Date of hire 10/1/2021, completed 12/1/2021. • #525 – Date of hire 1/18/2023, completed 2/7/2023. **Substitute Care/Respite Personnel:** • #543 – Date of hire 6/1/2023, completed 6/14/2023.	**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?)*: →	

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

Tag # 1A26.1 Employee Abuse Registry	Condition of Participation Level Deficiency		
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other	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 documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 47 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:** **Direct Support Professional (DSP):** • #516 – Date of hire 12/25/2021.	**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?)*: →	

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

Tag # 1A37 Individual Specific Training	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 17 Training Requirements: 17.1 Training Requirements for Direct Support Professional and Direct Support Supervisors:** Direct Support Professional (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports. 1. DSP/DSS must successfully complete within 30 calendar days of hire and prior to working alone with a person in service: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in Chapter 17.9 Individual Specific Training below. b. Complete DDSD training in standards precautions located in the New Mexico Waiver Training Hub. c. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. d. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). e. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, Crisis Prevention and Intervention (CPI)) before using Emergency Physical Restraint (EPR). Agency DSP and DSS shall maintain certification in a DDSD-approved system if any person they support has a BCIP that includes the use of EPR. f. Complete and maintain certification in a DDSD-approved Assistance with Medication Delivery (AWMD) course if	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 6 of 37 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Professional (DSP):** • Individual Specific Training (#506, 520, 521, 526, 527) **Service Coordination Personnel (SC):** • Individual Specific Training (#545)	**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?)*: →	

required to assist with medication delivery. g. Complete DDSD training regarding the HIPAA located in the New Mexico Waiver Training Hub. **17.1.13 Training Requirements for Service Coordinators (SC):** Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports. 2. A SC must successfully complete within 30 calendar days of hire and prior to working alone with a person in service: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported, and as outlined in the Chapter 17.10 Individual-Specific Training below. b. Complete DDSD training in standard precautions located in the New Mexico Waiver Training Hub. c. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. d. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). e. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using emergency physical restraint. Agency SC shall maintain certification in a DDSD-approved system if a person they support has a Behavioral Crisis Intervention Plan that includes the use of emergency physical restraint. f. Complete and maintain certification in			

AWMD if required to assist with medications. g. Complete DDSD training regarding HIPAA located in the New Mexico Waiver Training Hub.			

Tag # 1A43.1 General Events Reporting: Individual Reporting	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 19 Provider Reporting Requirements:** DOH-DDSD collects and analyzes system wide information for quality assurance, quality improvement, and risk management in the DD Waiver Program. Provider Agencies are responsible for tracking and reporting to DDSD in several areas on an individual and agency wide level. The purpose of this chapter is to identify what information Provider Agencies are required to report to DDSD and how to do so. **19.2 General Events Reporting (GER):** The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows: 1. DD Waiver Provider Agencies approved to provide Customized In- Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use the GER 2. DD Waiver Provider Agencies referenced above are responsible for entering specified information into a Therap GER module entry per standards set through the Appendix B GER Requirements and as identified by DDSD.	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 4 of 11 individuals. **The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within 2 business days and / or entered within 30 days for medication errors:** **Individual #3** • General Events Report (GER) indicates on 10/6/2022 the Individual was positive for COVID-19. (Communicable Disease). GER was approved 10/30/2022. **Individual #11** • General Events Report (GER) indicates on 10/24/2022 the Individual had a small scratch on left cheek. (Injury). GER was approved on 10/28/2022. **The following events were not reported in the General Events Reporting System as required by policy:** **Individual #1** • Documentation reviewed indicates on 2/10/2023 the Individual called 911 due to an altercation with housemate (Law Enforcement Use). No GER was found. • Documentation reviewed indicates on 4/23/2023 the Individual had a blank entry for Ketoconazole Shampoo 2% on the MAR (Medication Error). No GER was found. **Individual #2**	**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?)*: →	

3. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap. Events that are tracked for internal agency purposes and do not meet reporting requirements per DD Waiver Service Standards must be marked with a notification level of "Low" to indicate that it is being used internal to the provider agency. 4. GER does not replace a Provider Agency's obligations to report ANE or other reportable incidents as described in Chapter 18: Incident Management System. 5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities. 6. Each agency that is required to participate in General Event Reporting via Therap should ensure information from the staff and/or individual with the most direct knowledge is part of the report. a. Each agency must have a system in place that assures all GERs are approved per Appendix B GER Requirements and as identified by DDSD. b. Each is required to enter and approve GERs within 2 business days of discovery or observation of the reportable event. **19.2.1 Events Required to be Reported in GER:** The following events need to be reported in the Therap GER: when they occur during delivery of Supported Living, Family Living, Intensive Medical Living, Customized In-Home Supports, Customized Community Supports, Community Integrated Employment or Adult Nursing Services for DD Waiver participants aged 18 and older: 1. Emergency Room/Urgent Care/Emergency Medical Services	• Documentation reviewed indicates on 4/6 – 13, 2023 the Individual had blank entries for Aripiprazole 20 mg (7:00 AM) on the MAR (Medication Error). No GER was found. • Documentation reviewed indicates on 4/30/2023 the Individual had a blank entry for Atorvastatin 10 mg (7:00 PM) on the MAR (Medication Error). No GER was found. • Documentation reviewed indicates on 4/30/2023 the Individual had a blank entry for Benztropine MES .5 mg (7:00 PM) on the MAR (Medication Error). No GER was found. • Documentation reviewed indicates on 4/30/2023 the Individual had a blank entry for Denta 5000 plus cream (8:00 PM) on the MAR (Medication Error). No GER was found. • Documentation reviewed indicates on 4/30/2023 the Individual had a blank entry for Lamotrigine 100 mg (8:00 PM) on the MAR (Medication Error). No GER was found. • Documentation reviewed indicates on 4/30/2023 the Individual had a blank entry for Metformin HCL 1000 mg (5:00 PM) on the MAR (Medication Error). No GER was found. • Documentation reviewed indicates on 4/30/2023 the Individual had a blank entry for Metoprolol Tart 25 mg (8:00 PM) on the MAR (Medication Error). No GER was found.		

2. Falls Without Injury 3. Injury (including Falls, Choking, Skin Breakdown and Infection) 4. Law Enforcement Use 5. All Medication Errors 6. Medication Documentation Errors 7. Missing Person/Elopement 8. Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission 9. PRN Psychotropic Medication 10. Restraint Related to Behavior 11. Suicide Attempt or Threat 12. COVID-19 Events to include COVID-19 vaccinations.	• Documentation reviewed indicates on 4/5/2023 the Individual had a blank entry for Oxcarbazepine 600 mg (7:00 PM) and blank entry on 4/6 – 13 (7:00 AM and 7:00 PM) on the MAR (Medication Error). No GER was found. • Documentation reviewed indicates on 4/30/2023 the Individual had a blank entry for Tamsulosin HCL .4 mg (6:00 PM) on the MAR (Medication Error). No GER was found. • Documentation reviewed indicates on 4/30/2023 the Individual had a blank entry for Zinc Sulfate 50 mg (12:30 PM) on the MAR (Medication Error). No GER was found.		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
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 Quality Improvement System & Key Performance Indicators (KPIs)	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 ***Chapter 22 Quality Improvement Strategy (QIS):*** A QIS at the provider level is directly linked to the organization's service delivery approach or underlying provision of services. To achieve a higher level of performance and improve quality, an organization is required to have an efficient and effective QIS. The QIS is required to follow four key principles: 1. quality improvement work in systems and processes; 2. focus on participants; 3. focus on being part of the team; and 4. focus on use of the data. DD Waiver Provider Agencies have different business models, organizational structures, and approaches to service delivery. The DD Waiver can only truly assess progress, if the factors used to determine quality improvement (QI) are consistent across the system, i.e. QMB compliance surveys, IQRs, DD Waiver Service Standards, regulations (NMAC), litigation and Court Orders. As part of a QIS, Provider Agencies are required to evaluate their performance based on the four key principles outlined above. Provider Agencies are required to identify areas of improvement, issues that impact quality of services, and areas of non-compliance with the DD Waiver Service Standards or any other program requirements. The findings should help inform the agency's QI plan. **22.2 QI Plan and Key Performance Indicators (KPI):** Findings from a discovery process should result in a QI plan. The QI plan	Based on interview, the Agency did not maintain or implement a Quality Improvement System (QIS), as required by standards. **Review of information found:** **No evidence of a Quality Improvement Plan.** **When #545 was asked, if the Agency had a Quality Improvement Plan, which includes the Key Performance Indicators outlined by DDSD, the follow was reported:** • #545 stated, "I attempted to find the plan however was unable to locate the plan, it does exist. I will try again."	**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?)***:** →	

is used by an agency to continually determine whether the agency is performing within program requirements, achieving goals, and identifying opportunities for improvement. The QI plan describes the processes that the Provider Agency uses in each phase of the QIS: discovery, remediation, and sustained improvement. It describes the frequency of data collection, the source and types of data gathered, as well as the methods used to analyze data and measure performance. The QI plan must describe how the data collected will be used to improve the delivery of services and must describe the methods used to evaluate whether implementation of improvements is working. The QI plan shall address, at minimum, three key performance indicators (KPI). The KPI are determined by DOH-DDSQI on an annual basis or as determined necessary. The KPI are monitored for improvement on an annual basis and can change based on sustained improvement. The DDSQI will evaluate trends over time when determining new KPI. KPI updates will be through numbered memos, at least annually. **22.3 Implementing a QI Committee:** A QI committee must convene on at least a quarterly basis and more frequently if needed. The QI Committee convenes to review data; to identify any deficiencies, trends, patterns, or concerns; to remedy deficiencies; and to identify opportunities for QI. QI Committee meetings must be documented and include a review of at least the following: 1. Activities or processes related to discovery, i.e., monitoring and recording the findings; 2. The entities or individuals responsible for conducting the discovery/monitoring process; 3. The types of information used to measure performance; 4. The frequency with which performance is measured; and			

5. The activities implemented to improve performance.			

Tag #1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 3 Safeguards: 3.1 Decisions about Health Care or Other Treatment: Decision Consultation and Team Justification** **Process:** There are a variety of approaches and available resources to support decision making when desired by the person. The decision consultation and team justification processes assist participants and their health care decision makers to document their decisions. It is important for provider agencies to communicate with guardians to share with the Interdisciplinary Team (IDT) Members any medical, behavioral, or psychiatric information as part of an individual's routine medical or psychiatric care. For current forms and resources please refer to the DOH Website: https://nmhealth.org/about/ddsd/. **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 and Interdisciplinary Teams (IDTs) 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 Decision Consultation Process (DCP) is documented on the Decision Consultation and Team Justification Form (DC/TJF) and is used for health related issues when a person or their guardian/healthcare decision maker has concerns, needs more information about these types of issues or has decided not to follow all or part of a healthcare-related order, recommendation,	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 3 of 11 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: **Annual Physical *(LCA Only)*:** • Not Found (#2, 9) **Annual Dental Exam:** • Individual #1 - As indicated by collateral documentation reviewed, exam was completed on 6/7/2022. Follow-up was to be completed in 6 months. No evidence of follow-up found. • Individual #2 - As indicated by collateral documentation reviewed, the exam was not found. Per the DDSD file matrix, Dental Exams are to be conducted annually. • Individual #11 - As indicated by collateral documentation reviewed, exam was completed on 8/8/2022. Follow-up was to be completed in 6 months. No evidence of follow-up found.	**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?)*: →	

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 (e.g., nurses, therapists, dieticians, BSCs or PRS Risk Evaluator) or clinicians who have performed evaluations such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR); and d. recommendations made by a licensed professional through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), a Medical Emergency Response Plan (MERP) or another plan such as a Risk Management Plan (RMP) or a Behavior Crisis Intervention Plan (BCIP). **Chapter 20 Provider Documentation and Client Records: 20.2 Client Record 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 are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all 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 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. **20.5.4 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation*			

form generated from an e-CHAT in 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: 1. The Case Manager and Primary and Secondary Provider Agencies must communicate critical information to each other and will keep all required sections of Therap updated in order to have a current and thorough *Health Passport* and *Physician Consultation* Form available at all times. Required sections of Therap include the IDF, Diagnoses, and Medication History. 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. 3. Primary and Secondary Provider Agencies must assure that the current *Health Passport* and *Physician Consultation* form accompany each person when taken by the provider to a medical appointment, urgent care, emergency room, or are admitted to a hospital or nursing home. (If the person is taken by a family member or guardian, the *Health Passport* and *Physician Consultation* form must be provided to them.)			

4. The Physician Consultation form must be reviewed, and any orders or changes must be noted and processed as needed by the provider within 24 hours. 5. Provider Agencies must document that the *Health Passport* and *Physician Consultation* form and Advanced Healthcare Directives were delivered to the treating healthcare professional by one of the following means: a. document delivery using the *Appointments Results* section in *Therap Health Tracking Appointments*; and b. scan the signed *Physician Consultation Form* and any provided follow-up documentation into Therap after the person returns from the healthcare visit. **Chapter 13 Nursing Services: 13.2.3 General Requirements Related to Orders, Implementation, and Oversight** 1. Each person has a licensed primary care practitioner and receives an annual physical examination, dental care and specialized medical/behavioral care as needed. PPN communicate with providers regarding the person as needed. 2. Orders from licensed healthcare providers are implemented promptly and carried out until discontinued. a. The nurse will contact the ordering or on call practitioner as soon as possible, or within three business days, if the order cannot be implemented due to the person's or guardian's refusal or due to other issues delaying implementation of the order. The nurse must clearly document the issues and all attempts to resolve the problems with all involved parties. b. Based on prudent nursing practice, if a nurse determines to hold a practitioner's order, they are required to immediately document the circumstances and rationale for this decision and to notify			

the ordering or on call practitioner as soon as possible, but no later than the next business day. c. If the person resides with their biological family, and there are no nursing services budgeted, the family is responsible for implementation or follow up on all orders from all providers. Refer to Chapter 13.3 Adult Nursing Services.			

Tag # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 10 Living Care Arrangements (LCA): 10.3.5 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 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 20.6 Medication Administration Record (MAR) **Chapter 20 Provider Documentation and Client Records: 20.6 Medication Administration Record (MAR):** Administration of medications apply to all provider agencies of the following services: living supports, customized community supports, community integrated employment, intensive medical living supports. 1. Primary and secondary provider agencies are to utilize the Medication Administration Record (MAR) online in Therap. 2. Providers have until November 1, 2022, to have a current Electronic Medication Administration Record online in Therap in all settings where medications or treatments are delivered. 3. Family Living Providers may opt not to use MARs if they are the **sole** provider who supports the person and are related by affinity or consanguinity. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, a MAR online in Therap must be created and used by the DSP.	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 April, May and June 2023. Based on record review, 4 of 5 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #1 April 2023 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Ketoconazole Shampoo 2% (Every other day) – Blank 4/23 As indicated by the Medication Administration Records the individual is to take Gabapentin 600 mg (3 times daily). According to the Physician's Orders, Gabapentin 800 mg is to be taken 3 times daily. Medication Administration Record and Physician's Orders do not match. As indicated by the Medication Administration Records the individual is to take Meloxicam 7.5 mg (1 time daily). According to the Physician's Orders, Meloxicam 7.5 mg is to be taken 1 time daily as needed. Medication Administration Record and Physician's Orders do not match. May 2023 Medication Administration Records contained missing entries. No	**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?)***:** →	

4. Provider Agencies must configure and use the MAR when assisting with medication. 5. Provider Agencies Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 6. Provider agencies must include 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 and PRN medications and other treatments; all over the counter (OTC) or "comfort" medications or treatments; all self-selected herbal preparation approved by the prescriber, and/or vitamin therapy approved by prescriber. c. Documentation of all time limited or discontinued medications or treatments. d. The initials of the person administering or assisting with medication delivery. e. Documentation of refused, missed, or held medications or treatments. f. Documentation of any allergic reaction that occurred due to medication or treatments. g. For PRN medications or treatments including all physician approved over the counter medications and herbal or other supplements: 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	documentation found indicating reason for missing entries: • Ketoconazole Shampoo 2% (Every other day) – Blank 5/13, 30 As indicated by the Medication Administration Records the individual is to take Gabapentin 600 mg (3 times daily). According to the Physician's Orders, Gabapentin 800 mg is to be taken 3 times daily. Medication Administration Record and Physician's Orders do not match. As indicated by the Medication Administration Records the individual is to take Meloxicam 7.5 mg (1 time daily). According to the Physician's Orders, Meloxicam 7.5 mg is to be taken 1 time daily as needed. Medication Administration Record and Physician's Orders do not match. June 2023 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Tizanidine HCL 4 mg (3 times daily) – Blank 6/1 (1:00 PM and 6:00 PM) Individual #2 April 2023 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Aripiprazole 20 mg (1 time daily) – Blank 4/6 - 13 (7:00 AM) • Atorvastatin 10 mg (1 time daily) – Blank 4/30 (7:00 PM)		

number of doses that may be used in a 24-hour period; ii. clear follow-up detailed documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment; and iii. documentation of the effectiveness of the PRN medication or treatment. **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:	• Benztropine MES .5 mg (2 times daily) – Blank 4/30 (7:00 PM) • Denta 5000 plus cream (1 time daily) – Blank 4/30 (8:00 PM) • Lamotrigine 100 mg (2 times daily) – Blank 4/30 (8:00 PM) • Metformin HCL 1000 mg (2 times daily) – Blank 4/30 (5:00 PM) • Metoprolol Tart 25 mg (2 times daily) – Blank 4/30 (8:00 PM) • Oxcarbazepine 600 mg (2 times daily) – Blank 4/6 – 13 (7:00 AM), 4/5 – 13 (7:00 PM) • Tamsulosin HCL .4 mg (1 time daily) – Blank 4/30 (6:00 PM) • Zinc Sulfate 50 mg (1 time daily) – Blank 4/30 (12:30 PM) As indicated by the Medication Administration Records the individual is to take Quetiapine 25 mg (3 times daily). According to the Physician's Orders, Quetiapine Fumarate 25 mg is to be taken 2 times daily. Medication Administration Record and Physician's Orders do not match. No Physician's Orders were found for medications listed on the Medication Administration Records for the following medications: • Aripiprazole 20 mg • Denta 5000 plus cream • Oxcarbazepine 600 mg		

➢ 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: • Quetiapine Fumarate 50 mg (1 time daily) May 2023 No Physician's Orders were found for medications listed on the Medication Administration Records for the following medications: • Denta 5000 plus cream Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Quetiapine Fumarate 50 mg (1 time daily) Individual #4 April 2023 No Physician's Orders were found for medications listed on the Medication Administration Records for the following medications: • Pravastatin Sodium 200 mg May 2023 No Physician's Orders were found for medications listed on the Medication Administration Records for the following medications: • Pravastatin Sodium 200 mg Individual #11 April 2023 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Divalproex SOD ER 500 mg (3 times daily) – Blank 4/30 (2:00 PM and 8:00 PM)		

	• Melatonin 1 mg (1 time daily) – Blank 4/30 (8:00 PM) • Mirtazapine 15 mg (1 time daily) – Blank 4/30 (8:00 PM) • Olanzapine 5 mg (2 times daily) – Blank 4/30 (12:00 PM) • Olanzapine 20 mg (1 time daily) – Blank 4/15, 30 (8:00 PM) • Trazodone 50 mg 1 mg (1 time daily) – Blank 4/30 (8:00 PM)		

Tag # 1A09.0 Medication Delivery Routine Medication Administration	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 10 Living Care Arrangements (LCA): 10.3.5 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 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 20.6 Medication Administration Record (MAR) **Chapter 20 Provider Documentation and Client Records: 20.6 Medication Administration Record (MAR):** Administration of medications apply to all provider agencies of the following services: living supports, customized community supports, community integrated employment, intensive medical living supports. 1. Primary and secondary provider agencies are to utilize the Medication Administration Record (MAR) online in Therap. 2. Providers have until November 1, 2022, to have a current Electronic Medication Administration Record online in Therap in all settings where medications or treatments are delivered. 3. Family Living Providers may opt not to use MARs if they are the **sole** provider who supports the person and are related by affinity or consanguinity. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, a MAR online in Therap must be created and used by the DSP.	Medication Administration Records (MAR) were reviewed for the months of April, May and June 2023. Based on record review, 3 of 5 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #1 April 2023 Medication Administration Record did not contain the time the medication should be given: • Ketoconazole Shampoo 2% (Every other day) • Ketoconazole Cream 2% (Every other day) May 2023 Medication Administration Record did not contain the time the medication should be given: • Ketoconazole Shampoo 2% (Every other day) • Ketoconazole Cream 2% (Every other day) Individual #5 June 2023 Medication Administration Record did not contain the time the medication should be given: • Lisinopril 20 mg (1 time daily) • Lamotrigine 200 mg (1 time daily) Individual #11 April 2023	**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?)*: →	

4. Provider Agencies must configure and use the MAR when assisting with medication. 5. Provider Agencies Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 6. Provider agencies must include 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 and PRN medications and other treatments; all over the counter (OTC) or "comfort" medications or treatments; all self-selected herbal preparation approved by the prescriber, and/or vitamin therapy approved by prescriber. c. Documentation of all time limited or discontinued medications or treatments. d. The initials of the person administering or assisting with medication delivery. e. Documentation of refused, missed, or held medications or treatments. f. Documentation of any allergic reaction that occurred due to medication or treatments. g. For PRN medications or treatments including all physician approved over the counter medications and herbal or other supplements: 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	Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Mirtazapine 15 mg (1 time daily) May 2023 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Mirtazapine 15 mg (1 time daily)		

number of doses that may be used in a 24-hour period; ii. clear follow-up detailed documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment; and iii. documentation of the effectiveness of the PRN medication or treatment. **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.			

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 10 Living Care Arrangements (LCA): 10.3.5 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 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 20.6 Medication Administration Record (MAR) **Chapter 20 Provider Documentation and Client Records: 20.6 Medication Administration Record (MAR):** Administration of medications apply to all provider agencies of the following services: living supports, customized community supports, community integrated employment, intensive medical living supports. 1. Primary and secondary provider agencies are to utilize the Medication Administration Record (MAR) online in Therap. 2. Providers have until November 1, 2022, to have a current Electronic Medication Administration Record online in Therap in all settings where medications or treatments are delivered. 3. Family Living Providers may opt not to use MARs if they are the **sole** provider who supports the person and are related by affinity or consanguinity. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, a MAR online in Therap must be created and used by the DSP.	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 April, May, and June 2023. Based on record review, 4 of 5 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #1 April 2023 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Ketoconazole 2% Shampoo (PRN) No Physician's Orders were found for medications listed on the Medication Administration Records for the following medications: • Hydroxyzine PAM 25 mg (PRN) May 2023 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Ketoconazole 2% Shampoo (PRN) No Physician's Orders were found for medications listed on the Medication Administration Records for the following medications: • Hydroxyzine PAM 25 mg (PRN) Individual #2	**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?)*: →	

4. Provider Agencies must configure and use the MAR when assisting with medication. 5. Provider Agencies Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 6. Provider agencies must include 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 and PRN medications and other treatments; all over the counter (OTC) or "comfort" medications or treatments; all self-selected herbal preparation approved by the prescriber, and/or vitamin therapy approved by prescriber. c. Documentation of all time limited or discontinued medications or treatments. d. The initials of the person administering or assisting with medication delivery. e. Documentation of refused, missed, or held medications or treatments. f. Documentation of any allergic reaction that occurred due to medication or treatments. g. For PRN medications or treatments including all physician approved over the counter medications and herbal or other supplements: 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	April 2023 No Physician's Orders were found for medications listed on the Medication Administration Records for the following medications: • Acetaminophen 325 mg (PRN) • Acetaminophen 500 mg (PRN) • Airborne (PRN) • Ammonium Lactate 12% Cream (PRN) • Anbesol Max Strength Gel for Toothaches (PRN) • Artificial Tears Opth Sol (PRN) • Benzonatate 100 mg (PRN) • Cal-gest (PRN) • Diphenhydramine 25 mg (PRN) • Diphenhydramine 2% Cream (PRN) • Eucerin Cream (PRN) • Guaifenesin-DM 200-20 mg/10 ml (PRN) • Hydrocortisone 2.5% Cream (PRN) • Loperamide OTC 2 mg (PRN) • Mag/Alum/Sim Sus 30 ml (PRN) • Milk of Magnesia Suspension 30 ml (PRN) • Pink Bismuth 262 mg/15 ml (PRN) • Senna-Lax 8.6 mg (PRN)		

number of doses that may be used in a 24-hour period; ii. clear follow-up detailed documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment; and iii. documentation of the effectiveness of the PRN medication or treatment. **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:	• Sore Throat & Cough Lozenge (PRN) • Sore Throat Spray (PRN) • Sunscreen SPF 30 (PRN) • Theraflu NT Sever Cld-Cgh (PRN) • Triple Antibiotic Ointment (PRN) May 2023 No Physician's Orders were found for medications listed on the Medication Administration Records for the following medications: • Acetaminophen 325 mg (PRN) • Acetaminophen 500 mg (PRN) • Airborne (PRN) • Ammonium Lactate 12% Cream (PRN) • Anbesol Max Strength Gel for Toothaches (PRN) • Artificial Tears Opth Sol (PRN) • Benzonatate 100 mg (PRN) • Cal-gest (PRN) • Diphenhydramine 25 mg (PRN) • Diphenhydramine 2% Cream (PRN) • Eucerin Cream (PRN) • Guaifenesin-DM 200-20 mg/10 ml (PRN) • Hydrocortisone 2.5% Cream (PRN)		

➢ 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.	• Loperamide OTC 2 mg (PRN) • Mag/Alum/Sim Sus 30 ml (PRN) • Milk of Magnesia Suspension 30 ml (PRN) • Pink Bismuth 262 mg/15 ml (PRN) • Senna-Lax 8.6 mg (PRN) • Sore Throat & Cough Lozenge (PRN) • Sore Throat Spray (PRN) • Sunscreen SPF 30 (PRN) • Theraflu NT Sever Cld-Cgh (PRN) Triple Antibiotic Ointment (PRN) Individual #5 June 2023 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Acetaminophen 325 mg (PRN) • Airborne (PRN) • Anbesol Toothache drops (PRN) • Artificial Tears (PRN) • Benadryl Cream (PRN) • Benadryl 25 mg (PRN) • Pepto Bismol (PRN) • Maalox/Mylanta/Tums (PRN) • Chloraseptic Spray (PRN)		

	• Hydrocortisone 1% Cream (PRN) • Imodium AD (PRN) • Milk of Magnesia (PRN) • Ocean Mist (PRN) • Pamprin (PRN) • Robitussin (PRN) • Sun Block (PRN) • Theraflu (PRN) • Triple Antibiotic Ointment (PRN) Individual #11 April 2023 As indicated by the Medication Administration Records the individual is to take Pink Bismuth 262 MG/15 ML, take 10 ML (PRN). According to the Physician's Orders, Pink Bismuth take 30 ML is to be taken as needed. Medication Administration Record and Physician's Orders do not match. May 2023 As indicated by the Medication Administration Records the individual is to take Pink Bismuth 262 MG/15 ML, take 10 ML (PRN). According to the Physician's Orders, Pink Bismuth take 30 ML is to be taken as needed. Medication Administration Record and Physician's Orders do not match.		

Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 10 Living Care Arrangements (LCA): 10.3.5 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 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 20.6 Medication Administration Record (MAR) **Chapter 20 Provider Documentation and Client Records: 20.6 Medication Administration Record (MAR):** Administration of medications apply to all provider agencies of the following services: living supports, customized community supports, community integrated employment, intensive medical living supports. 1. Primary and secondary provider agencies are to utilize the Medication Administration Record (MAR) online in Therap. 2. Providers have until November 1, 2022, to have a current Electronic Medication Administration Record online in Therap in all settings where medications or treatments are delivered. 3. Family Living Providers may opt not to use MARs if they are the **sole** provider who supports the person and are related by affinity or consanguinity. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, a MAR online in Therap must be created and used by the DSP.	Medication Administration Records (MAR) were reviewed for the months of April, May, and June 2023. Based on record review, 1 of 5 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #11 April 2023 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Hydroxyzine 25 mg – PRN – 4/19, 25 (given 1 time) • Lorazepam .5 mg – PRN – 4/25 (given 1 time)	**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?)*: →	

4. Provider Agencies must configure and use the MAR when assisting with medication. 5. Provider Agencies Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 6. Provider agencies must include 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 and PRN medications and other treatments; all over the counter (OTC) or "comfort" medications or treatments; all self-selected herbal preparation approved by the prescriber, and/or vitamin therapy approved by prescriber. c. Documentation of all time limited or discontinued medications or treatments. d. The initials of the person administering or assisting with medication delivery. e. Documentation of refused, missed, or held medications or treatments. f. Documentation of any allergic reaction that occurred due to medication or treatments. g. For PRN medications or treatments including all physician approved over the counter medications and herbal or other supplements: 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 follow-up detailed documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment; and iii. documentation of the effectiveness of the PRN medication or treatment. **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.			

Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 10 Living Care Arrangements (LCA): 10.3.5 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 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 20.6 Medication Administration Record (MAR) **Chapter 13 Nursing Services: 13.2 General Nursing Services Requirements and Scope of Services:** The following general requirements are applicable for all RNs and LPNs in the DD Waiver. This section represents the scope of nursing services. Refer to Chapter 10 Living Care Arrangements (LCA) for residential provider agency responsibilities related to nursing. Refer to Chapter 11.6 Customized Community Supports (CCS) for agency responsibilities related to nursing. **13.3.2.3 Medication Oversight:** Medication Oversight by a DD Waiver nurse is required in Family Living when a person lives with a non-related Family Living provider; for all JCMs; and whenever non-related DSP provide AWMD medication supports. 1. The nurse must respond to calls requesting delivery of PRN medications from AWMD trained DSP, non-related Family Living providers. 2. Family Living providers related by affinity or consanguinity (blood, adoption, or marriage) are not required to contact 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 documentation of PRN authorization as required by standard for 1 of 5 Individuals. Individual #11 April 2023 No documentation of the verbal authorization from the Agency nurse prior to each administration / assistance of PRN medication was found for the following PRN medication: • Hydroxyzine 25 mg – PRN – 4/19, 25 (given 1 time) • Lorazepam .5 mg – PRN – 4/25 (given 1 time) May 2023 No documentation of the verbal authorization from the Agency nurse prior to each administration / assistance of PRN medication was found for the following PRN medication: • Hydroxyzine 25 mg – PRN – 5/23 - 26 (given 1 time), 5/14 (given 2 times) • Olanzapine 2.5 mg – PRN – 5/25 (given 1 time) June 2023 No documentation of the verbal authorization from the Agency nurse prior to each administration / assistance of PRN medication was found for the following PRN medication: • Hydroxyzine 25 mg – PRN – 6/4 (given 1 time)	**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?)*: →	

nurse prior to assisting with delivery of a PRN medication. **13.2.8.1.3 Assistance with Medication Delivery by Staff (AWMD):** For people who do not meet the criteria to self-administer medications independently or with physical assistance, trained staff may assist with medication delivery if: 1. Criteria in the MAAT are met. 2. Current written consent has been obtained from the person/guardian/surrogate healthcare decision maker. 3. There is a current Primary Care Practitioner order to receive AWMD by staff. 4. Only AWMD trained staff, in good standing, may support the person with this service. 5. All AWMD trained staff must contact the on-call nurse prior to assisting with a PRN medication of any type. a. Exceptions to this process must comply with the DDSD Emergency Medication list as part of a documented MERP with evidence of DSP training to skill level.			

Tag # 1A15 Healthcare Coordination - Nurse Availability / Knowledge	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 13 Nursing Services: 13.1 Overview of The Nurse's Role in The DD Waiver and Larger Health Care System:** Routine medical and healthcare services are accessed through the person's Medicaid State Plan benefits and through Medicare and/or private insurance for persons who have these additional types of insurance coverage. DD Waiver health related services are specifically designed to support the person in the community setting and complement but may not duplicate those medical or health related services provided by the Medicaid State Plan or other insurance systems. Nurses play a pivotal role in supporting persons and their guardians or legal Health Care Decision makers within the DD Waiver and are a key link with the larger healthcare system in New Mexico. DD Waiver Nurses identify and support the person's preferences regarding health decisions; support health awareness and self-management of medications and health conditions; assess, plan, monitor and manage health related issues; provide education; and share information among the IDT members including DSP in a variety of settings, and share information with natural supports when requested by individual or guardian. Nurses also respond proactively to chronic and acute health changes and concerns, facilitating access to appropriate healthcare services. This involves communication and coordination both within and beyond the DD Waiver. DD Waiver nurses must contact and consistently collaborate with the person, guardian, IDT members, Direct Support Professionals and all medical and behavioral providers including Medical Providers or Primary Care Practitioners (physicians, nurse practitioners or	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency nurse was unaware of the processes required by DDW Standards. The following was reported: **When Agency's RN was asked what is the minimum, face-to-face home visits you are required to conduct based on the individual's e-CHAT acuity level, the following was reported:** • RN #547 stated, "I would say it's once a month, I can only tell you what I do. I have access to the information. I would need to check and write it down." Per DDW Standards, the nurse is required to complete face to face visits for Non-Jackson Class Members and Jackson Class Member's based on the person's aspiration risk and acuity levels derived from the ARST and the e-CHAT or the Supported Living Category.	**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?)*: →	

physician assistants), Specialists, Dentists, and the Medicaid Managed Care Organization (MCO) Care Coordinators. **13.2 General Nursing Services Requirements and Scope of Services:** The following general requirements are applicable for all RNs and LPNs in the DD Waiver. This section represents the scope of nursing services. Refer to Chapter 10 Living Care Arrangements (LCA) for residential provider agency responsibilities related to nursing. Refer to Chapter 11.6 Customized Community Supports (CCS) for agency responsibilities related to nursing. **13.2.1 Licensing, Supervision, and Delivery of Nursing Services** All DD Waiver Nursing services must be provided by a Registered Nurse (RN) or licensed practical nurse (LPN) with a current license in good standing in New Mexico or under the Nurse Licensure Compact (NLC). The Nurse Licensure Compact is an agreement between New Mexico and other states that allows reciprocity for licensed nurses. 1. Nurses and Certified Medication Aides (CMAs) must comply with all aspects of the New Mexico Nursing Practice Act. a. An RN must provide routine supervision and oversight for LPNs, Certified Medication Aides (CMAs), and all direct support professionals (DSP) to whom they have delegated specific nursing tasks. b. An LPN or CMA may not work without the routine supervision and oversight of an RN. c. CMAs may not practice within their scope unless the DD Waiver Agency is also an active Certified Medication Aide Provider in good standing with the New Mexico Board of Nursing.			

13.2.2 Collaboration and the Hierarchy of Responsibility for Nursing Tasks: DD Waiver nursing is a community nursing service and is intended to support the individual across all aspects of their life. Nurses in all DD Waiver settings must routinely and professionally communicate and collaborate with one another. Nurses must also communicate with clinical and non- clinical partners within the Waiver system and throughout the larger health care system as needed for the benefit of the person's health and safety. **13.3.2 Ongoing Adult Nursing Services (OANS):** Ongoing Adult Nursing Services (OANS) are an array of services that are available to young adults and adults who require supports for specific chronic or acute health conditions. OANS may only begin after the Nursing Assessment and Consultation has been completed and the budget for additional ongoing ANS has been submitted and approved. The ANS Provider Agency nurse completes the designated ANS parameter tool to determine needed ongoing nursing hours. This includes any additional required information supporting the need for this service. Several elements of OANS are required if the person is a JCM; resides with non-related or host Family Living providers; or receives health related supports that require training and oversight by nursing in CCS-I, CCS-small group, CIE, or CIHS. OANS includes delivering nursing services that meet health needs described in the following categories which are described below: Healthcare Planning and Coordination, Aspiration Risk Management, Medication Oversight, Nurse Delegation, Medication Administration by a Licensed Nurse, and Coordination of Complex Conditions.			

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 3: Safeguards: Decisions about Health Care or Other Treatment: Decision Consultation and Team Justification** **Process:** There are a variety of approaches and available resources to support decision making when desired by the person. The decision consultation and team justification processes assist participants and their health care decision makers to document their decisions. It is important for provider agencies to communicate with guardians to share with the Interdisciplinary Team (IDT) Members any medical, behavioral, or psychiatric information as part of an individual's routine medical or psychiatric care. For current forms and resources please refer to the DOH Website: https://nmhealth.org/about/ddsd/. 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 and Interdisciplinary Teams (IDTs) are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources 2. The Decision Consultation Process (DCP) is documented on the Decision Consultation and Team Justification Form (DC/TJF) and is used for health related issues when a person or their guardian/healthcare decision maker has concerns, needs more information about these types of issues or has decided not to follow all or part of a healthcare-related order, recommendation,	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 6 of 11 individual Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Healthcare Passport:** • Did not contain Emergency Contact Information (#9, 11) • Guardianship/Healthcare Decision Maker (#6, 9, 11) • Did not contain Information regarding Insurance (#8, 9) • Did not contain Name of Physician (#6, 9, 11) **Electronic Comprehensive Health Assessment Tool (eCHAT):** • Not Found (#9) ***eCHAT Summary:*** • Not Found (#9) **Medication Administration Assessment Tool*:*** • Not Found (#9) **Aspiration Risk Screening Tool (ARST)*:*** • Not Found (#9)	**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?)*: →	

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 (e.g., nurses, therapists, dieticians, BSCs or PRS Risk Evaluator) or clinicians who have performed evaluations such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR); and d. recommendations made by a licensed professional through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), a Medical Emergency Response Plan (MERP) or another plan such as a Risk Management Plan (RMP) or a Behavior Crisis Intervention Plan (BCIP). **Chapter 10 Living Care Arrangements: Supported Living Requirements: 10.4.1.5.1 Monitoring and Supervision:** Supported Living Provider Agencies must: 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.	**Health Care Plans:** ***Bowel/Bladder Function:*** • Individual #4 – Per the Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ***Diabetes:*** • Individual #2 – According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Evidence indicated the plan was not current. ***Fluid Restriction:*** • Individual #2 – According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Evidence indicated the plan was not current. ***Hypertension:*** • Individual #4 – As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Intake Monitoring:*** • Individual #2 – As indicated by the IST section of ISP the individual is required to have a plan. Evidence indicated the plan was not current. ***Respiratory:*** • Individual #2 – As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. **Medical Emergency Response Plans:** ***Diabetes:*** • Individual #2 – Per the Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.		

e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist. 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). **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 are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all 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,	***Fluid Restriction:*** • Individual #2 – Per the Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ***Gastrointestinal Abdominal Pain:*** • Individual #2 – As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Hypernatremia:*** • Individual #4 – As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Hypertension:*** • Individual #4 – As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Respiratory:*** • Individual #2 – As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • Individual #4 – Per the Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ***Risk for Falls:*** • Individual #4 – As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.		

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 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. **20.5.4 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form generated from an e-CHAT in 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 13 Nursing Services: 13.1 Overview of The Nurse's Role in The DD Waiver and Larger Health Care System:** Routine medical and healthcare services are accessed through the person's Medicaid State Plan benefits and through Medicare and/or private insurance for persons who have these additional types of insurance coverage. DD Waiver health related services are specifically designed to support the person in the community setting and complement but may not duplicate those medical or health related			

services provided by the Medicaid State Plan or other insurance systems. Nurses play a pivotal role in supporting persons and their guardians or legal Health Care Decision makers within the DD Waiver and are a key link with the larger healthcare system in New Mexico. DD Waiver Nurses identify and support the person's preferences regarding health decisions; support health awareness and self-management of medications and health conditions; assess, plan, monitor and manage health related issues; provide education; and share information among the IDT members including DSP in a variety of settings, and share information with natural supports when requested by individual or guardian. Nurses also respond proactively to chronic and acute health changes and concerns, facilitating access to appropriate healthcare services. This involves communication and coordination both within and beyond the DD Waiver. DD Waiver nurses must contact and consistently collaborate with the person, guardian, IDT members, Direct Support Professionals and all medical and behavioral providers including Medical Providers or Primary Care Practitioners (physicians, nurse practitioners or physician assistants), Specialists, Dentists, and the Medicaid Managed Care Organization (MCO) Care Coordinators. **13.2.7 Documentation Requirements for all DD Waiver Nurses** **13.2.8 Electronic Nursing Assessment and Planning Process** **13.2.8.1 Medication Administration Assessment Tool (MAAT)** **13.2.8.2 Aspiration Risk Management Screening Tool (ARST)**			

13.2.8.3 The Electronic Comprehensive Health Assessment Tool (e-CHAT) **13.2.9.1 Health Care Plans (HCP)** **13.2.9.2 Medical Emergency Response Plan (MERP)**			

Tag # 1A29 Complaints / Grievances Acknowledgement	Standard Level Deficiency		
NMAC 7.26.3.6: A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process: A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Appendix A Client File Matrix**	Based on record review, the Agency did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 4 of 11 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: **Grievance/Complaint Procedure Acknowledgement:** • Not found (#6, 8, 9) • Not Current (#10)	**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 # 1A31 Client Rights / Human Rights	Condition of Participation Level Deficiency		
NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 2 Human Rights:** Civil rights apply to everyone including all waiver participants. Everyone including family members, guardians, advocates, natural supports, and Provider Agencies have a responsibility to	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review the Agency did not ensure the rights of Individuals was not restricted or limited for 2 of 11 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. <u>No documentation</u> was found regarding Human Rights Approval for the following: • Bell/Sensor on Bedroom Door – No evidence found of Human Rights Committee approval. (Individual #3) • Lock on Refrigerator/Freezer/Cabinet. - No evidence found of Human Rights Committee approval. (Individual #3) • Physical Restraint (Standing Side Body Hold) - No evidence found of Human Rights Committee approval. (Individual #11) • Use of Law Enforcement. No evidence found of Human Rights Committee approval. (Individual #11)	**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?)*: →	

make sure the rights of persons receiving services are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to best support the person and protecting their human and civil rights. ***2.2*** **Home and Community Based Services (HCBS): Consumer Rights and Freedom:** People with I/DD receiving DD Waiver services, have the same basic legal, civil, and human rights and responsibilities as anyone else. Rights shall never be limited or restricted unnecessarily, without due process and the ability to challenge the decision, even if a person has a guardian. Rights should be honored within any assistance, support, and services received by the person. **Chapter 3 Safeguards: 3.3.5 Interventions Requiring HRC Review and Approval** HRCs must review any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies that include a restriction of an individual's rights; this HRC should occur prior to implementation of the strategy or strategies proposed. Categories requiring an HRC review include, but are not limited to, the following: 1. response cost (See the BBS Guidelines for Using Response Cost); 2. restitution (See BBS Guidelines for Using Restitution); 3. emergency physical restraint (EPR); 4. routine use of law enforcement as part of a BCIP; 5. routine use of emergency hospitalization procedures as part of a BCIP; 6. use of point systems; 7. use of intense, highly structured, and specialized treatment strategies, including levels systems with response cost or failure to earn components;			

8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons; 9. use of PRN psychotropic medications; 10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand); 11. use of bed rails; 12. use of a device and/or monitoring system through RPST may impact the person's privacy or other rights; or 13. use of any alarms to alert staff to a person's whereabouts.			

Tag # 1A33.1 Board of Pharmacy - License	Standard Level Deficiency		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **Display of License and Inspection Reports** The following are required to be publicly displayed: • Current Custodial Drug Permit from the NM Board of Pharmacy • Current registration from the consultant pharmacist • Current NM Board of Pharmacy Inspection Report Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 16 Qualified Provider Agencies:** **16.5 Board of Pharmacy:** All DD Waiver Provider Agencies with service settings where medication administration / assistance to two or more unrelated individuals occurs must be licensed by the Board of Pharmacy and must follow all Board of Pharmacy regulations related to medication delivery including but not limited to: 1. pharmacy licensing; 2. medication delivery; 3. proper documentation and storage of medication; 4. use of a pharmacy policy manual; and 5. holding an active contract with a Pharmacy Consultant.	Based on observation, the Agency did not provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 1 of 9 residences: **Individual Residence:** • Current Custodial Drug Permit from the NM Board of Pharmacy with the current address of the residence (#2, 11) *Note: The following Individuals share a residence:* • #1, 4 • #2, 11	**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 # LS06 Family Living Requirements	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 10 Living Care Arrangements (LCA) Living Supports Family Living:** **10.3.9.2.1** Monitoring and Supervision Family Living Provider Agencies must: 1. Provide and document monthly face-to-face consultation in the Family Living home conducted by agency supervisors or internal service coordinators with the DSP and the person receiving services to include: a. reviewing implementation of the person's ISP, Outcomes, Action Plans, and associated support plans, including HCPs, MERPs, Health Passport, PBSP, CARMP, WDSI; b. scheduling of activities and appointments and advising the DSP regarding expectations and next steps, including the need for IST or retraining from a nurse, nutritionist, therapists or BSC; and c. assisting with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator, or other IDT members. 2. Monitor that the DSP implement and document progress of the AT inventory, Remote Personal Support Technology (RPST), physician and nurse practitioner orders, therapy, HCPs, PBSP, BCIP, PPMP, RMP, MERPs, and CARMPs. **10.3.9.2.1.1 Home Study:** An on-site Home Study is required to be conducted by the Family Living Provider agency initially, annually, and if there are any changes in the home location, household makeup, or other significant event. 1. The agency person conducting the Home Study must have a bachelor's degree in Human Services or related field or be at least 21 years of age, HS Diploma or GED	Based on record review, the Agency did not complete all DDSD requirements for approval of each direct support provider for 1 of 7 individuals. Review of the Agency files revealed the following items were not found, incomplete, and/or not current: **Family Living (Annual Update) Home Study:** • Individual #8 - Not Current. Last completed on 5/1/2022.	**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?)*: →	

and a minimum of 1-year experience with I/DD. 2. The Home Study must include a health and safety checklist assuring adequate and safe: a. Heating, ventilation, air conditioning cooling; b. Fire safety and Emergency exits within the home; c. Electricity and electrical outlets; and d. Telephone service and access to internet, when possible. 3. The Home Study must include a safety inspection of other possible hazards, including: a. Swimming pools or hot tubs; b. Traffic Issues; c. Water temperature that does not exceed a safe temperature (110^0 F). Anyone with a history of being unsafe in or around water while bathing, grooming, etc. or with a history of at least one scalding incident will have a regulated temperature control valve or device installed in the home. d. Any needed repairs or modifications 4. The home setting must comply with the CMS Final Settings Rule and ensure tenant protections, privacy, and autonomy.			

Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	Standard Level Deficiency		

Developmental Disabilities Waiver Service Standards Eff 11/1/2021
Chapter 10 Living Care Arrangement (LCA):
10.3.7 Requirements for Each Residence:
Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence:
1. has basic utilities, i.e., gas, power, water, telephone, and internet access;
2. supports telehealth, and/ or family/friend contact on various platforms or using various devices;
3. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher;
4. has a general-purpose first aid kit;
5. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift;
6. has water temperature that does not exceed a safe temperature (110^0 F). Anyone with a history of being unsafe in or around water while bathing, grooming, etc. or with a history of at least one scalding incident will have a regulated temperature control valve or device installed in the home.
7. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP;
8. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy;
	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 8 of 9 Living Care Arrangement residences.
	
	Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:
	
	Supported Living Requirements:
	
	• Water temperature in home exceeds safe temperature (110^0 F):
	  • Water temperature in home measured 127.4^0 F (#1, 4)
	
	  • Water temperature in home measured 127.2^0 F (#2, 11)
	
	Note: The following Individuals share a residence:
	• #1, 4
	• #2, 11
	
	Family Living Requirements:
	
	• Battery operated or electric smoke detectors or a sprinkler system (#8)
	
	• Carbon monoxide detectors (#7, 8, 9)
	
	• Fire extinguisher (#8)
	
	• Water temperature in home exceeds safe temperature (110^0 F)
	  • Water temperature in home measured 116.8^0 F (#3)
		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?)*: →	

9. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 10. supports environmental modifications, remote personal support technology (RPST), and assistive technology devices, 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; 11. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed; 12. has the phone number for poison control within line of site of the telephone; 13. has general household appliances, and kitchen and dining utensils; 14. has proper food storage and cleaning supplies; 15. has adequate food for three meals a day and individual preferences; and 16. has at least two bathrooms for residences with more than two residents. 17. Training in and assistance with community integration that include access to and participation in preferred activities to include providing or arranging for transportation needs or training to access public transportation. 18. Has Personal Protective Equipment available, when needed	• Water temperature in home measured 135^0 F (#5) • Water temperature in home measured 112.1^0 F (#6) • Water temperature in home measured 133.7^0 F (#8) • Water temperature in home measured 134.1^0 F (#9)		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag # LS26 Supported Living Reimbursement	**Standard Level Deficiency**		
NMAC 8.302.2 Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 3. Details of the services provided. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer. 4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to	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 4 individuals. Individual #2 February 2023 • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 2/28/2023. No documentation was found on 2/28/2023 to justify the 1 unit billed. • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 2/27/2023. Documentation received accounted for .50 unit. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 7 hours, which is less than the required amount. March 2023 • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 3/3/2023. Documentation received accounted for .50 unit. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount. April 2023 • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 4/6/2023. Documentation received accounted for .50	**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?)*: →	

any of the following for a period of at least six years from the payment date: a. treatment or care of any eligible recipient; b. services or goods provided to any eligible recipient; c. amounts paid by MAD on behalf of any eligible recipient; and d. any records required by MAD for the administration of Medicaid. **21.7 Billable Activities**: Specific billable activities are defined in the scope of work and service requirements for each DD Waiver service. In addition, any billable activity must also be consistent with the person's approved ISP. **21.9 Billable Units**: The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit, or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: 1. A day is considered 24 hours from midnight to midnight. 2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period. 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months.	unit. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U5) on 4/23/2023. Documentation received accounted for .50 unit. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 1 hour, which is less than the required amount.		

Tag # LS27 Family Living Reimbursement	Standard Level Deficiency		
NMAC 8.302.2 Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 3. Details of the services provided. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer. 4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date: a. treatment or care of any eligible recipient;	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Family Living Services for 3 of 7 individuals. Individual #6 February 2023 • The Agency billed 28 units of Family Living (T2033 HB) from 2/1/2023 through 2/28/2023. Documentation received accounted for 23.50 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for less than the required amount. • 2/4/2023 - Documentation received accounted for 6 hours. (.5 units) • 2/5/2023 - Documentation received accounted for 6 hours. (.5 units) • 2/11/2023 - Documentation received accounted for 5 hours. (.5 units) • 2/12/2023 - Documentation received accounted for 9 hours. (.5 units) • 2/18/2023 - Documentation received accounted for 6 hours. (.5 units) • 2/19/2023 - Documentation received accounted for 6 hours. (.5 units) • 2/20/2023 - Documentation received accounted for 9 hours. (.5 units) • 2/25/2023 - Documentation received accounted for 6 hours. (.5 units) • 2/26/2023 - Documentation received accounted for 9 hours. (.5 units) March 2023 • The Agency billed 31 units of Family Living (T2033 HB) from 3/1/2023 through 3/31/2023. Documentation received accounted for 27 units. As indicated by the DDW Standards at least 12 hours in a 24	**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?)*: →	

b. services or goods provided to any eligible recipient; c. amounts paid by MAD on behalf of any eligible recipient; and d. any records required by MAD for the administration of Medicaid. **21.7 Billable Activities**: Specific billable activities are defined in the scope of work and service requirements for each DD Waiver service. In addition, any billable activity must also be consistent with the person's approved ISP. **21.9 Billable Units**: The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit, or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: 1. A day is considered 24 hours from midnight to midnight. 2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period. 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months.	hour period must be provided in order to bill a complete unit. Documentation received accounted less than the required amount. • 3/4/2023 - Documentation received accounted for 7 hours. (.5 units) • 3/5/2023 - Documentation received accounted for 9 hours. (.5 units) • 3/11/2023 - Documentation received accounted for 6 hours. (.5 units) • 3/12/2023 - Documentation received accounted for 9 hours. (.5 units) • 3/18/2023 - Documentation received accounted for 6 hours. (.5 units) • 3/19/2023 - Documentation received accounted for 9 hours. (.5 units) • 3/25/2023 - Documentation received accounted for 6 hours. (.5 units) • 3/26/2023 - Documentation received accounted for 9 hours. (.5 units) April 2023 • The Agency billed 30 units of Family Living (T2033 HB) from 4/1/2023 through 4/30/2023. Documentation received accounted for 23.50 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted less than the required amount. • 4/1/2023 - Documentation received accounted for 6 hours. (.5 units) • 4/2/2023 - Documentation received accounted for 9 hours. (.5 units) • 4/7/2023 - Documentation received accounted for 10 hours. (.5 units) • 4/8/2023 - Documentation received accounted for 6 hours. (.5 units) • 4/9/2023 - Documentation received accounted for 9 hours. (.5 units) • 4/15/2023 - Documentation received accounted for 6 hours. (.5 units)		

	• 4/16/2023 - Documentation received accounted for 9 hours. (.5 units) • 4/21/2023 - Documentation received accounted for 9 hours. (.5 units) • 4/22/2023 - Documentation received accounted for 6 hours. (.5 units) • 4/23/2023 - Documentation received accounted for 9 hours. (.5 units) • 4/28/2023 - Documentation received accounted for 10 hours. (.5 units) • 4/29/2023 - Documentation received accounted for 6 hours. (.5 units) • 4/30/2023 - Documentation received accounted for 9 hours. (.5 units) Individual #8 February 2023 • The Agency billed 28 units of Family Living (T2033 HB) from 2/1/2023 through 2/28/2023. Documentation received accounted for 26 units. • 2/23/2023 - Documentation received accounted for 7.5 hours. (.5 units) • 2/24/2023 – Documentation received accounted for 9 hours (.5 units) • 2/26/2023 – Documentation received accounted for 11 hours (.5 units) • 2/27/2023 – Documentation received accounted for 11 hours (.5 units) March 2023 • The Agency billed 31 units of Family Living (T2033 HB) from 3/1/2023 through 3/31/2023. Documentation received accounted for 28.50 units. • 3/2/2023 - Documentation received accounted for 11 hours. (.5 units) • 3/5/2023 – Documentation received accounted for 11 hours (.5 units) • 3/12/2023 – Documentation received accounted for 11 hours (.5 units) • 3/19/2023 – Documentation received accounted for 11 hours (.5 units)		

	• 3/20/2023 – Documentation received accounted for 11 hours (.5 units)
	
	Individual #9
	February 2023
	• The Agency billed 28 units of Family Living (T2033 HB) from 2/1/2023 through 2/28/2023. Documentation did not contain the required elements on 2/1 – 28. Documentation received accounted for 0 units. The required elements were not met:
	  • Start and end time of each service encounter or other billable service interval;
	  • The signature or authenticated name of staff providing the service.
	
	March 2023
	• The Agency billed 31 units of Family Living (T2033 HB) from 3/1/2023 through 3/31/2023. Documentation did not contain the required elements on 3/1 - 31. Documentation received accounted for 0 units. The required elements were not met:
	  • Start and end time of each service encounter or other billable service interval;
	  • The signature or authenticated name of staff providing the service.
	
	April 2023
	• The Agency billed 30 units of Family Living (T2033 HB) from 4/1/2023 through 4/30/2023. Documentation did not contain the required elements on 4/1 – 30. Documentation received accounted for 0 units. The required elements were not met:
	  • Start and end time of each service encounter or other billable service interval;
	  • The signature or authenticated name of staff providing the service.		

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date: October 4, 2023

To: Michael Buszek, Ph.D., President / Executive Director

Provider: Transitional Lifestyles Community, LLC
Address: 8500 Menaul Blvd NE, A200
State/Zip: Albuquerque, New Mexico 87112

E-mail Address: tranlifellc@outlook.com

Region: Metro
Survey Date: June 5 – 15, 2023

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Supported Living and Family Living

Survey Type: Routine

Dear Mr. Buszek:

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 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.

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,

Monica Valdez, BS

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

Q.23.4.DDW.D3235.5.RTN.07.23.277