MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date:	August 9, 2023
To:	Mark Silversmith, Area Director
Provider:	The Tungland Corporation
Address:	724 West Animas Street
State/Zip:	Farmington, New Mexico 87401
E-mail Address:	mark.silversmith@sevitahealth.com
CC:	Susanna Streng, Interim State Director
E-Mail Address:	susanna.streng@sevitahealth.com
CC:	Christine Fritts, Quality Improvement Director
E-Mail Address:	christine.fritts@sevitahealth.com
Region:	Northwest
Routine Survey:	October 24 – November 4, 2022
Verification Survey:	July 3 – 12, 2023
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports, and Community Integrated Employment Services
Survey Type:	Verification
Team Leader:	Heather Driscoll, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Kathryn Conticelli, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Mark Silversmith,

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on October 24 – November 4, 2022*.

The Division of Health Improvement, Quality Management Bureau has determined your agency is now 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 ***(Repeat Findings)***
- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation ***(New / Repeat Findings)***
- Tag # 1A25.1 Caregiver Criminal History Screening ***(New Findings)***
- Tag # 1A26.1 Employee Abuse Registry ***(New Findings)***
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up ***(New / Repeat Findings)***
- Tag # 1A09.1 Medication Delivery PRN Medication Administration ***(New / Repeat Findings)***

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File (Other Required Documents) ***(New / Repeat Findings)***
- Tag # IS12 Person Centered Assessment (Community Inclusion) ***(Repeat Findings)***
- Tag # 1A09.0 Medication Delivery Routine Medication Administration ***(New Findings)***
- Tag # 1A09.1.0 Medication Delivery PRN Medication Administration ***(New / Repeat Findings)***
- Tag # 1A29 Complaints / Grievances Acknowledgement ***(New / Repeat Findings)***

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

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

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

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

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

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

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

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

Sincerely,

Heather Driscoll, AA

Heather Driscoll, AA
Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	July 3, 2023
Contact:	**<u>The Tungland Corporation</u>** Shaun Taylor, Area Director **<u>DOH/DHI/QMB</u>** Heather Driscoll, AA, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	*(Note: Entrance meeting was waived by provider)*
Exit Conference Date:	July 12, 2023
Present:	**<u>The Tungland Corporation</u>** Christine Fritts, Quality Improvement Director Michelle Halstead, Residential Program Director Mark Silversmith, Area Director Susanna Streng, Interim State Director Debbie Wegley, QA / QI Director **<u>DOH/DHI/QMB</u>** Heather Driscoll, AA, Team Lead/Healthcare Surveyor Kathryn Conticelli, Healthcare Surveyor Amanda Castaneda – Holguin, Healthcare Surveyor Supervisor **<u>DDSD - NW Regional Office</u>** Michele Groblebe, Regional Director Aaron Joplin, DDSD Generalist
Administrative Locations Visited:	0
Total Sample Size:	14 0 – *Former Jackson Class Members* 14 - Non-*Jackson* Class Members 5 - Supported Living 5 - Family Living 1 - Customized In-Home Supports 5 - Customized Community Supports 5 - Community Integrated Employment
Persons Served Records Reviewed	14
Direct Support Professional Records Reviewed	74
Direct Support Professional Interviewed during Routine Survey	10
Substitute Care/Respite Personnel Records Reviewed	11
Service Coordinator Records Reviewed	4
Nurse Interview completed during Routine Survey	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - 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
DOH – Internal Review Committee

Attachment B

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

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

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

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

Conditions of Participation (CoPs)

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

Service Domains and CoPs for Living Care Arrangements and Community Inclusion are as follows:

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

Potential Condition of Participation Level Tags if compliance is below 85%:
- **1A08.3 –** Administrative Case File: Individual Service Plan / ISP Components
- **1A32 –** Administrative Case File: Individual Service Plan Implementation
- **LS14 –** Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- **IS14 –** CCS / CIES Service Delivery Site Case File (ISP and Healthcare Requirements)

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

Potential Condition of Participation Level Tags if compliance is below 85%:
- **1A20 -** Direct Support 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.					

Agency: **The Tungland Corporation - Northwest Region**
Program: Developmental Disabilities Waiver
Service: Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports, and Community Integrated Employment Services
Survey Type: Verification
Routine Survey: **October 24 – November 4, 2022**
Verification Survey: **July 3 - 12, 2023**

Standard of Care	Routine Survey Deficiencies October 24 – November 4, 2022	Verification Survey New and Repeat Deficiencies July 3 – 12, 2023
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**	**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:	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 12 of 15 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Budget Worksheet:** • Not Current (#12) **Positive Behavioral Support Plan:** • Not Found (#2) • Not Current (#12) **Speech Therapy Plan (Therapy Intervention Plan TIP):** • Not Found (#2, 3, 10, 15, 17, 18) • Not Current (#12) **Occupational Therapy Plan (Therapy Intervention Plan TIP):** • Not Found (#2, 15, 17) • Not Current (#12) **Physical Therapy Plan (Therapy Intervention Plan TIP)**:	**New / Repeat Findings:** Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 2 of 14 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Speech Therapy Plan (Therapy Intervention Plan TIP):** • Not Current (#10) **Physical Therapy Plan (Therapy Intervention Plan TIP)**: • Not Current (#17) Based on the Agency's Plan of Correction approved on 3/15/2023, "The Area Director will create a document that will serve as a checklist for all Individual's document requirements, from which the Program Supervisors will work. Program Supervisors will use document check list and use the approved ISP for the new ISP year to verify which documents are needed for the new plan year."

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. 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.	• Not Found (#17) • Not Current (#14) **Documentation of Guardianship/Power of Attorney:** • Not Found (#2, 4, 5, 12, 13, 14, 18) **IDT meeting Minutes:** • Individual #15 – Not Found for Hospital discharge on 7/8/2022, 9/4/2022, and 9/18/2022. • Individual # 16 - Not Found for Hospital discharge on 10/19/2022.	No evidence of ongoing checklists completed by the Program Supervisors was provided during the Verification Survey completed July 3 – 12, 2023.

Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	Condition of Participation Level Deficiency	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 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).	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 12 of 15 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Annual ISP:** • Not Current (#5) **Addendum A**: • Not Found (#1, 2, 4, 6, 9, 12, 13, 16, 17, 18) **ISP Teaching and Support Strategies:** ***Individual #3:*** *TSS not found for the following Work / Learn Outcome Statement / Action Steps:* • "…will use the fluency techniques." ***Individual #4:*** *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:* • "… will tour the city or surrounding areas." • "Choose a place he enjoys." • "Take pictures of his choice." ***Individual #17:*** *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:* • "… will create a story."	**Repeat Findings:** After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 7 of 14 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Addendum A**: • Not Found (#1, 4, 6, 9, 13, 16, 17) Based on the Agency's Plan of Correction approved on 3/15/2023, "The Area Director will create a document that will serve as a checklist for all Individual's document requirements, from which the Program Supervisors will work. Program Supervisors will use document check list and use the approved ISP for the new ISP year to verify which documents are needed for the new plan year." No evidence of ongoing checklists completed by the Program Supervisors was provided during the Verification Survey completed July 3 – 12, 2023.

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	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 developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on 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 9 of 15 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 #12 • None found regarding: Live Outcome/Action Step: "…will research different items to gauge preferences" for 9/2022. Action step is to be completed 4 times per month. • None found regarding: Live Outcome/Action Step: "…will research different items to gauge preferences" for 7/2022 – 8/2022. Action step is to be completed 4 times per month. *Note: Document maintained by the provider was blank.* • None found regarding: Live Outcome/Action Step: "…will choose new item" for 9/2022. Action step is to be completed 1 time per month. • None found regarding: Live Outcome/Action Step: "…will choose new item" for 7/2022 – 8/2022. Action step is to be completed 1 time per month. *Note: Document maintained by the provider was blank.*	**New / Repeat Findings:** After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on 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 7 of 14 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 #12 • None found regarding: Live Outcome/Action Step: "…will obtain a new item to decorate with" for 5/2023. Action step is to be completed 2 times per month. • None found regarding: Live Outcome/Action Step: "…will decorate with his new item" for 5/2023. Action step is to be completed 2 times per month. Individual #17 • None found regarding: Live Outcome/Action Step: "Choose art" for 5/2023. Action step is to be completed 2 times per month. • None found regarding: Live Outcome/Action Step: "Display art" for 5/2023. Action step is to be completed 1 time per month.

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.	• None found regarding: Live Outcome/Action Step: "…will purchase new item for his bedroom" for 9/2022. Action step is to be completed 1 time per month. • None found regarding: Live Outcome/Action Step: "…will purchase new item for his bedroom" for 7/2022 – 8/2022. Action step is to be completed 1 time per month. *Note: Document maintained by the provider was blank.* Individual #17 • None found regarding: Live Outcome/Action Step: "Staff will assist …with discovering new sensory objects" for 7/2022 – 9/2022. Action step is to be completed 3 hours per month. • None found regarding: Live Outcome/Action Step: "…will pick the sensory object he wants in his collection" for 7/2022 – 9/2022. Action step is to be completed 2 times per month. **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #3 • None found regarding: Work/Learn Outcome/Action Step: "…will use the fluency techniques" for 7/2022 - 9/2022. Action step is to be completed 1 time per week. *Note: Document maintained by the provider was blank.* Individual #5 • According to the Live Outcome; Action Step for "Reach out to the community for information on different living situations." is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2022 and 9/2022. *Note: Document maintained by the provider was blank.*	**Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #3 • None found regarding: Live Outcome/Action Step: "…will research and plan trip to Africa" for 5/2023. Action step is to be completed 2 times per month. Individual #14 • None found regarding: Live Outcome/Action Step: "…will make his bed" for 5/2023. Action step is to be completed 8 times per month. **Customized In Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #6 • None found regarding: Live Outcome/Action Step: "Choose recipes" for 5/2023. Action step is to be completed 1 time per month. • None found regarding: Live Outcome/Action Step: "Gather ingredients" for 5/2023. Action step is to be completed 1 time per month. • None found regarding: Live Outcome/Action Step: "Prepare meal while demonstrating safety skills" for 5/2023. Action step is to be completed 1 time per month. **Customized Community Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #17 • None found regarding: Fun Outcome/Action Step: Choose an activity" for 5/2023. Action step is to be completed 2 times per month.

	• According to the Live Outcome; Action Step for "Set up appointments to see what these living situations have to offer her." is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2022 and 9/2022. *Note: Document maintained by the provider was blank.* • According to the Live Outcome; Action Step for "Discuss her different options for complete understanding." is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2022 and 9/2022. *Note: Document maintained by the provider was blank.* Individual #14 • None found regarding: Fun Outcome/Action Step: "…will research new foods" for 7/2022 and 9/2022. Action step is to be completed 4 times per month. • None found regarding: Fun Outcome/Action Step: "…will discuss new foods with family" for 7/2022 and 9/2022. Action step is to be completed 4 times per month. • None found regarding: Fun Outcome/Action Step: "…will pick the entrée for the family" for 7/2022 and 9/2022. Action step is to be completed 4 times per month. • None found regarding: Fun Outcome/Action Step: "…will assist with preparing the new foods" for 7/2022 and 9/2022. Action step is to be completed 4 times per month. **Customized In Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #6	• None found regarding: Fun Outcome/Action Step: "Participate in chosen activity" for 5/2023. Action step is to be completed 2 times per month. • None found regarding: Fun Outcome/Action Step: "Share story of activity" for 5/2023. Action step is to be completed 1 time per month. **Community Integrated Employment Services Data Collection / Data Tracking/Progress with regards to ISP Outcomes:** Individual #9 • None found regarding: Work/Learn Outcome/Action Step: "Adding one new job task" for 5/2023. Action step is to be completed 1 time per month. Individual #13 • None found regarding: Work/Learn Outcome/Action Step: "…will gather supplies" for 5/2023. Action step is to be completed 2 times per month. • None found regarding: Work/Learn Outcome/Action Step: "…will practice job duties to perfect them" for 5/2023. Action step is to be completed 2 times per month. Based on the Agency's Plan of Correction approved on 3/15/2023, "Area Director will forward monthly action/goal tracking data sheets to QA/QI for final review prior to being sent for electronic filing. Documents will be submitted to QA/QI by the 15th of the following month. If any documents are missing or do not meet the required standard, QA/QI will defer to responsible Program Supervisor and/or Program Director for correction, via email. QA/QI will do quarterly review of all Data Collection/Data Tracking of all individual's in Tungland services during quarterly QA/QI review of Outcome Tracking data sheets."

	• None found regarding: Live Outcome/Action Step: "Gather ingredients" for 9/2022. Action step is to be completed 1 time per month. • None found regarding: Live Outcome/Action Step: "Prepare meal" for 9/2022. Action step is to be completed 1 time per month. **Customized Community Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #17 • None found regarding: Fun Outcome/Action Step: "…will choose a sensory item for his story" for 8/2022 – 9/2022. Action step is to be completed 2 times per month. • None found regarding: Fun Outcome/Action Step: "…will create a story" for 8/2022 – 9/2022. Action step is to be completed 2 times per month. • None found regarding: Fun Outcome/Action Step: "…will share his story" for 8/2022 – 9/2022. Action step is to be completed 2 times per month. **Community Integrated Employment Services Data Collection / Data Tracking/Progress with regards to ISP Outcomes:** Individual #2 • None found regarding: Work/Learn, Outcome/Action Step: "…will practice job tasks" for 8/2022. Action step is to be completed 4 times per month. Individual #9 • None found regarding: Work/learn, Outcome/Action Step: "Check TJ Maxx website for old job position" for 7/2022 - 8/2022. Action step is to be completed 1 time per month.	No evidence of QA/QI quarterly review was provided during the Verification Survey completed July 3 – 12, 2023.

	• None found regarding: Work/learn, Outcome/Action Step: "Follow up on application process after applying once monthly" for 7/2022 - 8/2022. Action step is to be completed 1 time per month. • None found regarding: Work/learn, Outcome/Action Step: "Adding one new job task" for 9/2022. Action step is to be completed 1 time per month. Individual #13 • None found regarding: Work/Learn, Outcome/Action Step: "…will gather supplies" for 7/2022. Action step is to be completed 4 times per month. • None found regarding: Work/Learn, Outcome/Action Step: "…will learn job duties" for 7/2022. Action step is to be completed 4 times per month.	

Tag # IS12 Person Centered Assessment (Community Inclusion)	Standard Level Deficiency	Standard Level Deficiency
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 11: Community Inclusion: 11.4 Person Centered Assessments (PCA) and Career Development Plans (CDP)** Agencies who are providing CCS and/or CIE are required to complete a person-centered assessment (PCA). A PCA is a person-centered planning tool that is intended to be used for the service agency to get to know the person whom they are supporting and to help identify the individual needs and strengths to be addressed in the ISP. The PCA should provide the reader with a good sense of who the person is and is a means of sharing what makes an individual unique. The information gathered in a PCA should be used to guide community inclusion services for the individual. Recommended methods for gathering information include paper reviews, interviews with the individual, guardian or anyone who knows the individual well including staff, family members, friends, BSC therapist, school personnel, employers, and providers. Observations in the community, home visits, neighborhood/environmental observations research on community resources, and team input are also reliable means of gathering valuable information. A Career Development Plan (CDP), developed by the CIE Provider Agency with input from the CCS Provider, must be in place for job seekers or those already working to outline the tasks needed to obtain, maintain, or seek advanced opportunities in employment. For those who are employed, the career development plan addresses topics such as a plan to fade paid supports from the worksite or strategies to improve opportunities for career advancement. CCS and CIE Provider Agencies must adhere to the following requirements related to a PCA and Career Development Plan: 1. A PCA should contain, the following major topics, at a minimum: a. information about the person's background	Based on record review, the Agency did not maintain a confidential case file for Individuals receiving Inclusion Services for 7 of 8 individuals. Review of the Agency individual case files revealed the following items were not found: • Annual Review - Person Centered Assessment (Individual #2, 6, 9, 12, 13, 14, 18)	**Repeat Findings:** Based on record review, the Agency did not maintain a confidential case file for Individuals receiving Inclusion Services for 1 of 8 individuals. Review of the Agency individual case files revealed the following items were not found: • Annual Review - Person Centered Assessment (Individual #18) Based on the Agency's Plan of Correction approved on 3/15/2023, " Each individual will have a document/report tracking sheet that the Area Director will use to track the timely completion of documents due to the case manager 14 days prior to the Annual ISP meeting. If issues are discovered during the review process, the Area Director will return the PCA/CDP to the Program Manager for timely correction. Area Director will ensure that issues are fixed timely, in order for the PCA/CDP to still be submitted on time" No evidence of document/report tracking sheet completed by the Area Director was provided during the Verification Survey completed July 3 – 12, 2023.

and current status; b. the person's strengths and interests and how they are known; c. conditions for success to integrate into the community, including conditions for job success (for those who are working or wish to work); and d. support needs for the individual. 2. The agency must involve the individual and describe how they were involved in development of the PCA. A guardian and those who know the person best must also be included in the development of the PCA, as applicable. 3. Timelines for completion: The initial PCA must be completed within the first 90 calendar days of the person receiving services. Thereafter, the Provider Agency must ensure that the PCA is reviewed and updated with the most current information, annually. A more extensive update of a PCA must be completed every five years. PCAs completed at the 5-year mark should include a narrative summary of progress toward outcomes from initial development, changes in support needs, major life changes, etc. If there is a significant change in a person's circumstance, a new PCA should be considered because the information in the PCA may no longer be relevant. A significant change may include but is not limited to losing a job, changing a residence or provider, and/or moving to a new region of the state. 4. If a person is receiving more than one type of service from the same provider, one PCA with information about each service is acceptable. 5. PCA's should be signed and dated to demonstrate that the assessment was reviewed and updated with the most current information, at least annually. 6. A career development plan is developed by the CIE provider with input from the CCS provider, as appropriate, and can be a separate document or be added as an addendum to a PCA. The career development plan should have specific action steps that identify who does what and by when.		

Standard of Care	Routine Survey Deficiencies October 24 – November 4, 2022	Verification Survey New and Repeat Deficiencies July 3 – 12, 2023
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 # 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	**N/A**	**New Findings:** After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation indicating Caregiver Criminal History Screening was completed as required for 1 of 89 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Direct Support Professional (DSP):** • #597 – Date of hire 5/3/2023.

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 # 1A26.1 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 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	**N/A**	**New Finding:** After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 2 of 89 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:** **Direct Support Professional (DSP):** • #597 – Date of hire 5/3/2023. • #603 – Date of hire 7/6/2023.

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.		

Standard of Care	Routine Survey Deficiencies October 24 – November 4, 2022	Verification Survey New and Repeat Deficiencies July 3 – 12, 2023
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses, and seeks to prevent occurrences of abuse, neglect, and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag #1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Condition of Participation Level Deficiency**	**Condition of Participation Level Deficiency**
Developmental Disabilities 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,	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 and interview, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 10 of 15 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):*** **Annual Physical:** • Not Found (#12) **Annual Physical *(LCA Only)*:** • Not Found (#3, 5, 16, 17) **Annual Physical *(Individuals Receiving Inclusion Services Only)*:** • Not Found (#9, 13) **Annual Dental Exam:** • Individual #12 - As indicated by collateral documentation reviewed, the exam was not found. Per the DDSD file matrix, Dental Exams are to be conducted annually.	**New / Repeat Findings:** After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on record review and interview, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 10 of 14 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):*** **Annual Physical:** • Not Found (#12) **Annual Dental Exam:** • Individual #12 - As indicated by collateral documentation reviewed, the exam was not found. Per the DDSD file matrix, Dental Exams are to be conducted annually. • Individual #15 - As indicated by collateral documentation reviewed, the exam was completed on 5/8/2022. No evidence of exam results was found. **Emergency Medicine:**

recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT (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	• Individual #15 - As indicated by collateral documentation reviewed, the exam was completed on 5/8/2022. No evidence of exam results was found. • Individual #17 - As indicated by collateral documentation reviewed, the exam was not found. Per the DDSD file matrix, Dental Exams are to be conducted annually. **Gastroenterology:** • Individual #18 – As indicated by collateral documentation reviewed, the exam was completed on 10/27/2022. No evidence of exam results was found. **Psychiatry:** • Individual #4 - As indicated by collateral documentation reviewed, exam was completed on 3/11/2022. Follow-up was to be completed in 2 months. No evidence of follow-up found.	• Individual #17 - As indicated by collateral documentation reviewed, the visit was completed on 2/5/2023. No evidence of visit results was found. • Individual #17 - As indicated by collateral documentation reviewed, the visit was completed on 3/30/2023. No evidence of visit results was found. • Individual #18 - As indicated by collateral documentation reviewed, the visit was completed on 10/13/2022. No evidence of visit results was found. • Individual #18 - As indicated by collateral documentation reviewed, the visit was completed on 10/14/2022. No evidence of visit results was found. • Individual #18 - As indicated by collateral documentation reviewed, the visit was completed on 1/5/2023. No evidence of visit results was found. • Individual #18 - As indicated by collateral documentation reviewed, the visit was completed on 3/11/2023. No evidence of visit results was found. • Individual #18 - As indicated by collateral documentation reviewed, the visit was completed on 5/4/2023. No evidence of visit results was found. Based on the Agency's Plan of Correction approved on 3/15/2023, "On an Annual Basis, the QA/QI department will use the calendar produced by the Program Director and Area Director and ensure that timely notification of when annual appointments are due for all individuals and go out to Program Supervisors and Program Directors for their follow-

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		up. Program Directors and Area Director will confirm completion of all Annual appointments by entering the completion data on spreadsheet that will indicate due by date of all annual appointments and check off the date when the annuals are completed." No evidence of the calendar or spread sheets being completed by the QA / QI department was provided during the Verification Survey completed July 3 – 12, 2023.

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 # 1A09.0 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. 4. Provider Agencies must configure and use the MAR when assisting with medication.	**N/A**	**New Findings:** Medication Administration Records (MAR) were reviewed for the month of June 2023. Based on record review, 1 of 5 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #17 June 2023 Medication Administration Records did not contain the route of administration for the following medications: • Lactulose 10mg / 15ml (1 time every other day)

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 # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency	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. 4. Provider Agencies must configure and use the MAR when assisting with medication.	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 August, September, and October 2022. Based on record review, 1 of 5 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #17 As indicated by medication found in the home the individual is to take the following medication. Review of the Medication Administration Record found no evidence that medication is documented on the MAR. • Bisacodyl 10mg RTL Suppository (PRN)	**New / Repeat Findings:** After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the month of 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 #17 June 2023 No Physician's Orders were found for medications listed on the Medication Administration Records for the following medications: • Antibiotic Ointment (PRN) • Bisacodyl Rectal Suppository (PRN) • Chloraseptic Throat Spray (PRN) • Ibuprofen 200mg (PRN) • Mucinex DM Liquid (PRN) • Mylanta (PRN) • Pepto Bismol (PRN) • Robitussin DM Cough Syrup (PRN) • Robitussin CF (PRN)

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 # 1A09.1.0 Medication Delivery PRN Medication Administration	Standard Level Deficiency	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. 4. Provider Agencies must configure and use the MAR when assisting with medication.	Medication Administration Records (MAR) were reviewed for the months of August, September, and October 2022. Based on record review, 1 of 5 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #17 October 2022 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Lactulose 10gm / 15ml Oral Solution – PRN – 11/12 (given 1 time)	**New / Repeat Findings:** Medication Administration Records (MAR) were reviewed for the month of 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 #17 June 2023 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 200mg – PRN – 6/14 (given 1 time) Medication Administration Records did not contain the number of doses that may be used in a 24-hour period: • Lactulose 10mg / 15ml (PRN)

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 # 1A29 Complaints / Grievances Acknowledgement	Standard Level Deficiency	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 15 of 15 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: **Grievance/Complaint Procedure Acknowledgement:** • Not Found (#1, 2, 3, 4, 5, 6, 9, 10, 12, 13, 14, 15, 16, 17, 18)	**New / Repeat Findings:** Based on record review, the Agency did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 8 of 14 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: **Grievance/Complaint Procedure Acknowledgement:** • Not Found (#9) • Not Current (#3, 6, 12, 15, 16, 17, 18) Based on the Agency's Plan of Correction approved on 3/15/2023, "Tungland acknowledges that the Grievance/Complaint Procedure Acknowledgement was not sent to the QMB Audit Team, due a misunderstanding about what was required. This will not happen again. All Grievance/Complaint Procedure Acknowledgement Forms were found and are in place" and "QA/QI department will verify during Quarterly QA/QI meetings, that all Grievance/Complaint Procedure and Acknowledgement Forms are in place." No evidence of the QA / QI Meeting minutes showing that the documents are in the case files was provided during the Verification Survey completed July 3 – 12, 2023.

Standard of Care	Routine Survey Deficiencies December 3 – 6, 2018	Verification Survey New and Repeat Deficiencies July 3 – 12, 2023
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency specified in the service plan.*		
Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	**Standard Level Deficiency**	**COMPLETE**
Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A43.1 General Events Reporting: Individual Reporting	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses, and seeks to prevent occurrences of abuse, neglect, and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A09 Medication Delivery Routine Medication Administration	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # LS06 Family Living Requirements	**Standard Level Deficiency**	**COMPLETE**
Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*		
Tag # IS25 Community Integrated Employment Services	**Standard Level Deficiency**	**COMPLETE**
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag # LS26 Supported Living Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag # LS27 Family Living Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag #IH32 Customized In-Home Supports Reimbursement	**Standard Level Deficiency**	**COMPLETE**

	Verification Survey Plan of Correction, On-going QA/QI, and Responsible Party	Completion Date
Tag # 1A08 Administrative Case File (Other Required Documents)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	**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 # 1A32 Administrative Case File: Individual Service Plan Implementation	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # IS12 Person Centered Assessment (Community Inclusion)	**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 # 1A25.1 Caregiver Criminal History Screening	**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 # 1A26.1 Employee Abuse Registry	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag #1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # 1A09.0 Medication Delivery Routine Medication Administration	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A09.1 Medication Delivery PRN Medication Administration	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A29 Complaints / Grievances Acknowledgement	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date: October 5, 2023

To: Mark Silversmith, Area Director

Provider: The Tungland Corporation
Address: 724 West Animas Street
State/Zip: Farmington, New Mexico 87401

E-mail Address: mark.silversmith@sevitahealth.com

CC: Susanna Streng, Interim State Director
E-Mail Address: susanna.streng@sevitahealth.com

CC: Christine Fritts, Quality Improvement Director
E-Mail Address: christine.fritts@sevitahealth.com

Region: Northwest
Routine Survey: October 24 – November 4, 2022
Verification Survey: July 3 – 12, 2023
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports, and Community Integrated Employment Services

Survey Type: Verification

Dear Mr. Mark Silversmith,

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Monica Valdez, BS

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

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