

Date: January 12, 2016

To: D. Glen Carlberg, Executive Director
 Provider: Collins Lake Ranch (Collins Lake Autism Center)
 Address: 254 Encinal Rd.
 State/Zip: Cleveland, New Mexico 87715

E-mail Address: glen.carlberg.cl@gmail.com
Collinslakeranch@gmail.com

Board Chair: Steve Smaby, Chairperson of Board
 E-Mail Address: Steve.smaby@gmail.com

Region: Northeast
 Routine Survey: June 6 – 8, 2016
 Verification Survey: December 12 – 13, 2016
 Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012: Living Supports** (Supported Living); **Inclusion Supports** (Customized Community Supports)

Survey Type: Verification

Team Leader: Tricia L. Hart, AAS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Corrina Strain, BSN, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Carlberg;

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 June 6 - 8, 2016*.

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

Compliance with Conditions of Participation.

However, due to the new/repeat standard level deficiencies your agency will 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:

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



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
1170 North Solano Suite D Las Cruces, New Mexico 88001**
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 Amanda Castaneda at 575-373-5716 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Tricia L. Hart, AAS

Tricia L. Hart, AAS
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	December 12, 2016
Contact:	<u>Collins Lake Ranch</u> Malissia Romero, Internal Service Coordinator <u>DOH/DHI/QMB</u> Tricia L. Hart, Team Lead/Healthcare Surveyor
Entrance Conference Date:	December 12, 2016
Present:	<u>Collins Lake Ranch (Collins Lake Autism Center)</u> D. Glen Carlberg, Executive Director Malissia Romero, Internal Service Coordinator Marcella Martinez, Operations Manager <u>DOH/DHI/QMB</u> Tricia L. Hart, AAS, Team Lead/Healthcare Surveyor Corrina Strain, RN, BSN, Healthcare Surveyor
Exit Conference Date:	December 13, 2016
Present:	<u>Collins Lake Ranch (Collins Lake Autism Center)</u> D. Glen Carlberg, Executive Director Malissia Romero, Internal Service Coordinator Marcella Martinez, Operations Manager Helen Cordova, RN, Agency Nurse <u>DOH/DHI/QMB</u> Tricia L. Hart, AAS, Team Lead/Healthcare Surveyor Corrina Strain, RN, BSN, Healthcare Surveyor <u>DDSD - Northeast Regional Office</u> Jenny Bartos, Northeast Regional Office Case Manager Coordinator
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 3 0 - <i>Jackson</i> Class Members 3 - <i>Non-Jackson</i> Class Members 3 - Supported Living 3 - Customized Community Supports
Total Homes Visited	Number: 2
❖ Supported Living Homes Visited	Number: 2 <i>Note: The following Individuals share a SL residence:</i> ➤ #2, 3
Persons Served Records Reviewed	Number: 3

QMB Report of Findings – Collins Lake Ranch (Collins Lake Autism Center) – Northeast Region – December 12 – 13, 2016

Survey Report #: Q.17.2.DDW.11536837.2.VER.01.17.012

Direct Support Personnel Records Reviewed Number: 18

Service Coordinator Records Reviewed Number: 1

Administrative Processes and Records Reviewed:

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

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

Attachment B

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

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

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

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

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in the following Service Domains.

Case Management Services (Four Service Domains):

- Plan of Care: ISP Development & Monitoring
- Level of Care
- Qualified Providers
- Health, Safety and Welfare

Community Living Supports / Inclusion Supports (Three Service Domains):

- Service Plans: ISP Implementation
- Qualified Provider
- Health, Safety and Welfare

Conditions of Participation (CoPs)

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

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP (See the next section for a list of CoPs). The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for

significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

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

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

Service Domain: Plan of Care ISP Development & Monitoring

Condition of Participation:

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

Condition of Participation:

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

Service Domain: Level of Care

Condition of Participation:

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

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

Service Domain: Qualified Providers

Condition of Participation:

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

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

Service Domain: Service Plan: ISP Implementation

Condition of Participation:

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

Service Domain: Health, Welfare and Safety

Condition of Participation:

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

Condition of Participation:

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

QMB Determinations of Compliance

Compliance with Conditions of Participation

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

Partial-Compliance with Conditions of Participation

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

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

Non-Compliance with Conditions of Participation

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

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

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

Introduction:

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

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: <http://dhi.health.state.nm.us/qmb>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Crystal Lopez-Beck at Crystal.Lopez-Beck@state.nm.us for assistance.

The following limitations apply to the IRF process:

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

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

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

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

Agency: Collins Lake Ranch (Collins Lake Autism Center) - Northeast Region
Program: Developmental Disabilities Waiver
Service: *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports)
Monitoring Type: Verification Survey
Routine Survey: June 6 – 8, 2016
Verification Survey: December 12 – 13, 2016

Standard of Care	Routine Survey Deficiencies June 6 – 8, 2016	Verification Survey New and Repeat Deficiencies December 12 – 13, 2016
<p>Service Domain: Qualified Providers – <i>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.</i></p>		
Tag # 1A37 Individual Specific Training	Condition of Participation Level Deficiency	Standard Level Deficiency
<p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 10 of 11 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <p>Direct Support Personnel (DSP):</p> <ul style="list-style-type: none"> • Individual Specific Training (DSP # 200, 201, 202, 203, 204, 205, 206, 207, 208) <p>Service Coordination Personnel (SC):</p> <ul style="list-style-type: none"> • Individual Specific Training (SC # 210) 	<p>New / Repeat Findings:</p> <p>Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 2 of 18 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <p>Direct Support Personnel (DSP):</p> <ul style="list-style-type: none"> • Individual Specific Training (DSP # 214, 223)

<p>aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.</p> <p>CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;</p> <p>CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training.</p> <p>CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training: A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living</p>		
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must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDS Statewide Training Database as specified in DDS Policy T-001: Reporting and Documentation for DDS Training Requirements.

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

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

<p>A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDS Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDS Statewide Training Database as specified in DDS Policy T-001: Reporting and Documentation for DDS Training Requirements.</p> <p>B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc.), and information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.</p> <p>CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDS Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDS</p>		
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Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;

Tag #1A40 Provider Requirement Accreditation	Standard Level Deficiency	Standard Level Deficiency
<p>NMAC 7.26.6.6 OBJECTIVE: A. These regulations are being promulgated to promote and assure the provision of quality services to persons with developmental disabilities residing in community agencies. B. These regulations are being promulgated as part of a quality assurance initiative requiring all community agencies providing services to persons with developmental disabilities and contracting with the developmental disabilities division to be accredited by the commission on accreditation of rehabilitation facilities (CARF).</p> <p>7.26.6.14 CARF STANDARDS MANUAL FOR ORGANIZATIONS SERVING PEOPLE WITH DEVELOPMENTAL DISABILITIES: Community agencies governed by these regulations are required to meet applicable provisions of the most current edition of the "CARF Standards Manual for Organizations Serving People with Disabilities". Sections of the CARF standards may be waived by the Department when deemed not applicable to the services provided by the community agency.</p> <p>Long Term Services Division Policy - Accreditation of Long Term Services Division Funded Providers eff. August 30, 2004 A. Mandate for Accreditation The Department of Health, Long Term Services Division (hereafter referred to as the Division) will contract only with agencies/organizations accredited in compliance with this policy. 1. Within eighteen (18) months of an initial contract or change in exemption status as defined in this policy, the contractor must provide the Division with written verification of accreditation from the Commission on</p>	<p>Based on observation and interview, the Agency did not obtain the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (The Council) accreditation or the applicable waiver from the Developmental Disability Support Division, within eighteen (18) months of an initial contract.</p> <p>Observation of the administrative office found no evidence of accreditation or exemption.</p> <p>When #211 was asked if the Agency had evidence of current CARF or Counsel accreditation or a waiver from DDSD the following was reported:</p> <ul style="list-style-type: none"> • #211 stated, "I've been in communication with them. I've sent e-mails and made several phone calls. We've been working on it." <p>Additionally, per interview with the DDSD Northeast Regional Office Director, the Agency is "out of compliance at this time. Accreditation was due June 2015."</p>	<p>Repeat Finding:</p> <p>Based on observation, the Agency did not obtain the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (The Council) accreditation or the applicable waiver from the Developmental Disability Support Division, within eighteen (18) months of an initial contract.</p> <p>Observation of the administrative office found no evidence of accreditation or exemption.</p> <p>During the on-site Verification Survey it was found that the Agency had not initiated the accreditation process in a timely manner. As part of the Agency's Plan of Correction process, the Agency Director had completed a 2-day training Seminar in October 2016. However, the Agency did not submit their application to request a CARF Accreditation review until December 12, 2016. The CARF Accreditation survey is currently pending, with review possible in April or May 2017. As of the end of the on-site verification survey, December 13, 2016, the Agency has yet to complete the Accreditation process.</p>

Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (The Council).

2. Except as provided in this policy, the Division may terminate its contract with a contractor that fails to maintain an accreditation status of at least one year, regardless of any appeal process available from CARF or the Council.

Tag # 1A43 General Events Reporting	Standard Level Deficiency	Standard Level Deficiency
<p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy: General Events Reporting Effective 1/1/2012</p> <p>1. Purpose To report, track and analyze significant events experiences by adult participants of the DD Waiver program, which do not meet criteria for abuse, neglect or exploitation, or other “reportable incident” as defined by the Incident Management Bureau of the Division of Health Improvement, Department of Health, but which pose a risk to individuals served. Analysis of reported significant events is intended to identify emerging patterns so that preventative actions can be identified at the individual, provider agency, regional and statewide levels.</p> <p>II. Policy Statements A. Designated employees of each agency will enter specified information into the General Events Reporting section of the secure website operated under contract by Therap Services within 2 business days of the occurrence or knowledge by the reporting agency of any of the following defined events in which DDSD requires reporting: Chocking, Missing Person, Suicide Attempt or Threat, Restraint related to Behavior, Serious Injury including Skin Breakdown, Fall (with or without injury), Out of Home Placement and Infections... Providers shall utilize the “Significant Events Reporting System Guide” to assure that events are reported correctly for DDSD tracking purposes. At providers’ discretion additional events may be tracked</p>	<p>Based on record review the Agency did not follow the General Events Reporting requirements as indicated by the policy for 2 of 3 individuals.</p> <p>Agency record review revealed the following incidents were not entered in the General Events Reporting System as required:</p> <p>Individual #1</p> <ul style="list-style-type: none"> Agency’s internal report indicates on 9/23/2015 the Individual was found to have round “scrapish” looking sores on the top of his left and right feet. (Injury) Agency’s internal report indicates on 12/18/2015 the Individual broke skin and raised a hematoma on his arm and hand while hitting a wall and counter top. (Injury) Agency’s internal report indicates on 1/25/2016 the Individual was found with a cut on his right knee; old scabs on left leg were reopened; had bruises on the side of his left thigh, and “big” bruise on right buttock (Injury) Documentation found on file indicated the individual was seen in the ER on 6/2/2016. (Unplanned use of ER/Urgent Care/EMT) <p>Individual #2</p> <ul style="list-style-type: none"> Agency’s internal report indicates on 12/31/2015 911 was called. The Mora County Deputy safely placed individual #2 into his patrol vehicle and transported him to the Las Vegas Hospital. (Use of Law Enforcement and Unplanned use of ER/Urgent care/EMT) Agency’s internal report indicates on 05/25/2016 the 	<p>New / Repeat Findings:</p> <p>Based on record review the Agency did not follow the General Events Reporting requirements as indicated by the policy for 3 of 3 individuals.</p> <p>Agency record review revealed the following incidents were not entered in the General Events Reporting System as required:</p> <p>Individual #1</p> <ul style="list-style-type: none"> Agency’s internal report indicates on 7/1/2016 the individual tripped while walking and “scraped his right cheek.” (Fall with injury) Agency’s internal report indicates on 7/15/2016 the individual trips and “scrapes” his left hand and left knee. (Fall with injury) <p>Individual #2</p> <ul style="list-style-type: none"> Agency’s internal report indicates on 7/23/2016 the individual had a seizure and fell to the ground; had swelling and bruising to right eye. (Fall with injury) Agency’s internal report indicates on 10/7/2016 the individual fell in the shower while having a seizure; was taken to Urgent Care. (Unplanned use of ER/Urgent Care/EMT) <p>Individual #3</p> <ul style="list-style-type: none"> Agency’s internal report indicates on 9/3/2016 individual #2 ran through the door and as he pushed it open he knocked individual #3 to the ground; had a “gash” to his head and was bleeding; called 911. (Unplanned use of ER/Urgent Care/EMT) Agency’s internal report indicates on 11/15/2016

<p>within the Therap General Events Reporting which are not required by DDSD such as medication errors.</p> <p>B. General Events Reporting does not replace agency obligations to report abuse, neglect, exploitation and other reportable incidents in compliance with policies and procedures issued by the Department's Incident Management Bureau of the Division of Health Improvement.</p>	<p>Individual was up on his own (unassisted) and was stepping backwards and fell over his bead working table. (Fall without injury)</p> <ul style="list-style-type: none"> • Agency's internal report indicates on 05/25/2016 the Individual hit a wall with his fist causing his hand to swell. (Injury) 	<p>the individual became upset and eloped; sheriffs were called to assist in locating the individual. (Missing Person, Elopement or AWOL)</p> <ul style="list-style-type: none"> • Agency's internal report indicates on 12/4/2016 the individual lost balance and fell in the bathroom; had a "scrape". (Fall with injury)
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Standard of Care	Routine Survey Deficiencies June 6 – 8, 2016	Verification Survey New and Repeat Deficiencies December 12 – 13, 2016
<p>Service Domain: Health and Welfare – <i>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.</i></p>		
Tag # 1A03 CQI System	Standard Level Deficiency	Standard Level Deficiency
<p>STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS</p> <p>d. PROVIDER shall have a Quality Management and Improvement Plan in accordance with the current MF Waiver Standards and/or the DD Waiver Standards specified by the DEPARTMENT. The Quality Management and Improvement Plan for DD Waiver Providers must describe how the PROVIDER will determine that each waiver assurance and requirement is met. The applicable assurances and requirements are: (1) level of care determination; (2) service plan; (3) qualified providers; (4) health and welfare; (5) administrative authority; and, (6) financial accountability. For each waiver assurance, this description must include:</p> <ol style="list-style-type: none"> i. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance; ii. The entities or individuals responsible for conducting the discovery/monitoring processes; iii. The types of information used to measure performance; and, iv. The frequency with which performance is measured. 	<p>Based on record review and interview, the Agency did not implement their Continuous Quality Management System as required by standard.</p> <p>Review of the Agency’s CQI Plan revealed the following:</p> <ul style="list-style-type: none"> • The Agency’s Continuous Quality Improvement Plan provided during the on-site survey (June 6 - 8, 2016) was dated “2014”. No evidence was found indicating when the document had been reviewed or updated. Also, based on evidence found during the on-site survey and reflected in this report of findings the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency. <p>When Surveyors asked if there was a current QA/QI Plan, the following was reported:</p> <ul style="list-style-type: none"> • #211 stated, “There is no annual QA/QI.” <p>When Surveyors asked how often the QA/QI committee meet, the following was reported:</p> <ul style="list-style-type: none"> • #211 stated, “Quarterly, in conjunction with board meetings.” Board meeting minutes provided contained no evidence of QA/QI review. 	<p>Repeat Findings:</p> <p>Based on record review, the Agency did not develop and implement a Continuous Quality Management System.</p> <p>Review of the findings from the June 6 – 8, 2016 survey indicated the Agency had multiple deficiencies noted. Nevertheless, during the verification survey the agency continues to have substantial deficiencies, which either were not corrected nor addressed since the last survey</p>

<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</p> <p>CHAPTER 6 (CCS) 3. Agency Requirements: I. Quality Assurance/Quality Improvement (QA/QI)</p> <p>Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities.</p> <p>1. Development of a QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.</p> <p>2. Implementing a QI Committee: The QA/QI committee shall convene at least quarterly and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting shall be documented. The QA/QI review should address at least the following:</p> <ul style="list-style-type: none"> a. The extent to which services are delivered in accordance with ISPs, associated support plans and WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History 		
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<p>Screening requirements;</p> <ul style="list-style-type: none"> d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. <p>3. The Provider Agencies must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:</p> <ul style="list-style-type: none"> a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and g. Significant program changes. <p>CHAPTER 12 (SL) 3. Agency Requirements: B. Quality Assurance/Quality Improvement (QA/QI) Program: Supported Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.</p>		
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<p>1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.</p> <p>2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:</p> <ol style="list-style-type: none"> a. Implementation of the ISP and the extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration, and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns in reportable incidents; and g. Results of improvement actions taken in previous quarters. <p>2.The Provider Agency must complete a QA/QI report annually by February 15th of each calendar</p>		
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<p>year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH, and upon request from DDS the report must be submitted to the relevant DDS Regional Offices. The report will summarize:</p> <ol style="list-style-type: none"> a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis, Trends in Category II significant events; d. Patterns in medication errors; e. Action taken regarding individual grievances; f. Presence and completeness of required documentation; g. A description of how data collected as part of the agency's QA/QI plan was used, what quality improvement initiatives were undertaken, and the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and h. Significant program changes. 		
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Standard of Care	Routine Survey Deficiencies June 6 – 8, 2016	Verification Survey New and Repeat Deficiencies December 12 – 13, 2016
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 Agency Case File	Standard Level Deficiency	COMPLETE
Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	Standard Level Deficiency	COMPLETE
Tag # LS14 / 6L14 Residential Case File	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 # 1A11.1 Transportation Training	Standard Level Deficiency	COMPLETE
Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency	COMPLETE
Tag # 1A28.1 Incident Mgt. System - Personnel Training	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A36 Service Coordination Requirements	Standard Level Deficiency	COMPLETE
Tag # 1A37 Individual Specific Training	Condition of Participation 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 # 1A08.2 Healthcare Requirements	Standard Level Deficiency	COMPLETE
Tag # 1A06 Policy and Procedure Requirements	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A09.1 Medication Delivery PRN Medication Administration	Standard Level Deficiency	COMPLETE
Tag # 1A27.2 Duty to Report IRs Filed	Standard Level Deficiency	COMPLETE

QMB Report of Findings – Collins Lake Ranch (Collins Lake Autism Center) – Northeast Region – December 12 – 13, 2016

Survey Report #: Q.17.2.DDW.11536837.2.VER.01.17.012

During On-Site and/or IRs Not Reported by Provider		
Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency	COMPLETE
Tag # 1A31 Client Rights/Human Rights	Standard Level Deficiency	COMPLETE
Tag # 1A31.1 Human Rights Policy & Procedures	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A33.1 Board of Pharmacy – License	Standard Level Deficiency	COMPLETE
Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)	Standard Level Deficiency	COMPLETE
Tag # 6L25.1 Residential Requirements (Physical Environment – SL/FL)	Standard Level Deficiency	COMPLETE
<i>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.</i>		
Tag # IS30 Customized Community Supports Reimbursement	Standard Level Deficiency	COMPLETE

Date: February 3, 2017

To: D. Glen Carlberg, Executive Director
Provider: Collins Lake Ranch (Collins Lake Autism Center)
Address: 254 Encinal Rd.
State/Zip: Cleveland, New Mexico 87715

E-mail Address: glen.carlberg.cl@gmail.com
Collinslakeranch@gmail.com

Board Chair: Steve Smaby, Chairperson of Board
E-Mail Address: Steve.smaby@gmail.com

Region: Northeast
Routine Survey: June 6 – 8, 2016
Verification Survey: December 12 – 13, 2016
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012: Living Supports** (Supported Living); **Inclusion Supports** (Customized Community Supports)

Survey Type: Verification

Team Leader: Tricia L. Hart, AAS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Corrina Strain, BSN, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Carlberg;

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.



QMB Report of Findings – Collins Lake Ranch (Collins Lake Autism Center) – Northeast Region – December 12 – 13, 2016

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,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.17.2.DDW.11536837.2.VER.09.17.034