

Date: October 24, 2018

To: Ruthie Roman, Director
 Provider: Links of Life, LLC
 Address: 653 Utah Avenue
 State/Zip: Las Cruces, New Mexico 88005

E-mail Address: rroman@linksoflife.org

Owner: Chandra Baker
 E-Mail Address: cbakeruop2004@yahoo.com

Region: Southwest
 Routine Survey: February 2 - 9, 2018
 Verification Survey: October 1 – 3, 2018

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012 & 2018:** Support Living; Customized Community Supports

Survey Type: Verification

Team Leader: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Wolf Krusemark, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Yolanda Herrera, RN, Nurse Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau;

Dear Ms. Roman;

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 February 2 – 9, 2018*.

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 at 575-373-5716, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Deb Russell, BS

Deb Russell, BS
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date: October 1, 2018

Contact: **Links of Life, LLC**
Chandra Baker, Chief Operations Officer/Owner
Taneshia Brown, Quality Assurance/Quality Improvement Director

DOH/DHI/QMB
Deb Russell, BS, Team Lead/Healthcare Surveyor

Entrance Conference Date: October 2, 2018

Present: **Links of Life, LLC**
Chandra Baker, Chief Operations Officer/Owner
Ruthie Roman, Director
Taneshia Brown, Quality Assurance/Quality Improvement Director

DOH/DHI/QMB
Deb Russell, BS, Team Lead/Healthcare Surveyor
Wolf Krusemark, AA, Healthcare Surveyor
Yolanda Herrera, RN, Nurse Healthcare Surveyor

Exit Conference Date: October 3, 2018

Present: **Links of Life, LLC**
Chandra Baker, Chief Operations Officer/Owner
Ruthie Roman, Director
Taneshia Brown, Quality Assurance/Quality Improvement Director

DOH/DHI/QMB
Deb Russell, BS, Team Lead/Healthcare Surveyor
Wolf Krusemark, AA, Healthcare Surveyor
Yolanda Herrera, RN, Nurse Healthcare Surveyor

DDSD - Southwest Regional Office
Angie Brooks, Regional Director

Administrative Locations Visited 1

Total Sample Size 8

0 - *Jackson* Class Members
8 - *Non-Jackson* Class Members

8 - Supported Living
8 - Customized Community Supports

Persons Served Records Reviewed 8

Direct Support Personnel Records Reviewed 79

Service Coordinator Records Reviewed 2

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 and/or 6 or more Condition of Participation level deficiencies overall, as well as widespread Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

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: Links of Life, LLC - Southwest Region
Program: Developmental Disabilities Waiver
Service: 2012 & 2018: Supported Living & Customized Community Supports
Survey Type: Verification
Routine Survey: February 2 - 9, 2018
Verification Survey: October 1 - 3, 2018

Standard of Care	Routine Survey Deficiencies February 2 – 9, 2018	Verification Survey New and Repeat Deficiencies October 1 - 3, 2018
<i>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.</i>		
Tag # 1A43.1 General Events Reporting - Individual Approval	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 </p>	<p>Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 5 of 8 individuals.</p> <p>The following events were not reported in the General Events Reporting System as required by Policy:</p> <p>Individual #1</p> <ul style="list-style-type: none"> Documentation reviewed indicates on 10/2/2017 the Individual hit himself on the head with a rock, staff cleaned the wound. No GER was found, however once Surveyors identified issue the Agency entered and approved Injury GER on 2/9/2018. Documentation reviewed indicates on 9/5/2017 the Individual fell and hit his face during a seizure. No GER was found, however once Surveyors identified issue the Agency entered and approved Injury GER on 2/9/2018. Documentation reviewed indicates on 8/17/2017 the Individual fell hitting his elbow during a seizure. No GER was found, however once Surveyors identified issue the Agency entered and approved Injury GER on 2/9/2018. 	<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 4 of 8 individuals.</p> <p>The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within 2 business days:</p> <p>Individual #1</p> <ul style="list-style-type: none"> General Events Report (GER) indicates on 2/2/2018 the Individual was taken to the Emergency Room. (Emergency Room). GER was approved 2/13/2018. <p>Individual #6</p> <ul style="list-style-type: none"> General Events Report (GER) indicates on 3/24/2018 the Individual was injured. (Injury). GER was approved 3/28/2018. <p>Individual #7</p> <ul style="list-style-type: none"> General Events Report (GER) indicates on 2/14/2018 the Individual was given a PRN Medication. (PRN Psychotropic Medication). GER was approved 2/26/2018.

Events Reporting System Guide" to assure that events are reported correctly for DDSD tracking purposes. At providers' discretion additional events may be tracked within the Therap General Events Reporting which are not required by DDSD such as medication errors.

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.

- Documentation reviewed indicates on 7/1/2017 the Individual had multiple seizures and went to the hospital. No GER was found, however once Surveyors identified issue the Agency entered and approved Hospitalization GER on 2/9/2018.

- Documentation reviewed indicates on 7/12/2017 the Individual was aggressive, staff held him Individual had injuries. No GER was found, however once Surveyors identified issue the Agency entered and approved Injury / Restraint GER on 2/9/2018

Individual #2

- Documentation reviewed indicates on 06/17/2017 the Individual jumped fence and ran, police called. No GER was found, however once Surveyors identified issue the Agency entered and approved Law Enforcement GER on 2/9/2018.

Individual #7

- Documentation reviewed indicates on 05/16/2017 the Individual after morning medication started to hit his bed and spit at staff. Staff called for PRN Medications. No GER was found, however once Surveyors identified issue the Agency entered and approved PRN Medication GER on 2/9/2018.

- Documentation reviewed indicates on 05/27/17 the Individual started spitting at staff, threw his shoes at staff, started hitting himself. PRN medications were called into the nurse. No GER was found, however once Surveyors identified issue the Agency entered and approved PRN Medication GER on 2/9/2018.

- Documentation reviewed indicates on 06/12/2017 the Individual started to spit, yell and hit his bed. PRN Medication had to be called into nurse. No

- General Events Report (GER) indicates on 9/4/2018 the Individual was taken to Urgent Care. (Urgent Care). GER was approved 9/8/2018.

Individual #8

- General Events Report (GER) indicates on 8/24/2018 the Individual was injured. (Injury). GER was approved 8/29/2018.

GER was found, however once Surveyors identified issue the Agency entered and approved PRN Medication GER on 2/9/2018.

Individual #8

- Documentation reviewed indicates on 03/10/2017 the Individual was not given 12pm medication. No GER was found, however once Surveyors identified issue the Agency entered and approved Medication Error GER on 2/9/2018.
- Documentation reviewed indicates on 03/16/2017 the Individual was not given his 12pm medication. No GER was found, however once Surveyors identified issue the Agency entered and approved Medication Error GER on 2/9/2018.
- Documentation reviewed indicates on 07/11/2017 the Individual was not assisted with medications on 07/10/2017. No GER was found, however once Surveyors identified issue the Agency entered and approved Medication Error GER on 2/9/2018.

The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and approved within 2 business days:

Individual #1

- General Events Report (GER) indicates on 12/26/2017 the Individual had fallen with helmet, no visible injuries (Injury). GER was approved on 1/03/2018.
- General Events Report (GER) indicates on 12/02/2017 the Individual fell with helmet on during a seizure, redness noted on head (Injury). GER was approved on 12/08/2017.

	<ul style="list-style-type: none"> • General Events Report (GER) indicates on 11/07/2017 the Individual had scrape on top of head, staff cleaned area (Injury). GER was approved on 11/15/2017. • General Events Report (GER) indicates on 7/23/2017 the Individual went to the Emergency Room for multiple seizures, continued to have seizures at hospital (Hospital). GER was approved on 7/27/2017. <p>Individual #3</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 11/22/2017 the Individual became aggressive, staff verbally redirected several times, then utilized CPI. (Restraint). GER was approved on 11/29/2017. <p>Individual #7</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 11/11/2017 the Individual was walking up the bleachers and hit his right hip and leg. (Injury). GER was approved on 11/15/2017. • General Events Report (GER) indicates on 12/05/2017 the Individual was upset, spitting and tearing his shirt. PRN medication was called in to nurse. (PRN Medication) GER was approved on 12/08/2017. • General Events Report (GER) indicates on 12/06/2017 the Individual was upset tearing off his clothes and tearing up his mattress. PRN medication was called in to nurse. (PRN Medication) GER was approved on 12/12/2017. 	
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Standard of Care	Routine Survey Deficiencies February 2 – 9, 2018	Verification Survey New and Repeat Deficiencies October 1 – 3, 2018
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 # 1A08.1 Agency Case File - Progress Notes	Standard Level Deficiency	COMPLETE
Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	Condition of Participation Level Deficiency	COMPLETE
Tag # IS11 / 5I11 Reporting Requirements Inclusion Reports	Standard Level Deficiency	COMPLETE
Tag # LS14 / 6L14 Residential Case File	Standard Level Deficiency	COMPLETE
Tag # LS17 / 6L17 Requirements (Community Living Reports)	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	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A22 Agency Personnel Competency	Standard Level Deficiency	COMPLETE
Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	Standard Level Deficiency	COMPLETE
Tag # 1A28.1 Incident Mgt. System - Personnel Training	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A37 Individual Specific Training	Standard Level Deficiency	COMPLETE
Service Domain: Health and Welfare - The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.		
Tag # 1A03 CQI System - Quality Improvement / Quality Assurance Plan and Components	Standard Level Deficiency	COMPLETE
Tag # 1A06 Policy and Procedure Requirements	Standard Level Deficiency	COMPLETE
Tag # 1A08.2 Healthcare Requirements	Standard 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 # 1A09.2 Medication Delivery - Nurse Approval for PRN Medication	Standard Level Deficiency	COMPLETE
Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation	Standard Level Deficiency	COMPLETE
Tag # 1A31 Client Rights/Human Rights	Standard Level Deficiency	COMPLETE
Tag # 1A31.1 Human Rights Policy & Procedures	Standard 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
Service Domain: Medicaid Billing/Reimbursement - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.		
Tag # IS30 Customized Community Supports Reimbursement	Standard Level Deficiency	COMPLETE
Tag # LS26 / 6L26 Supported Living Reimbursement	Standard Level Deficiency	COMPLETE

Date: November 8, 2018

To: Ruthie Roman, Director
Provider: Links of Life, LLC
Address: 653 Utah Avenue
State/Zip: Las Cruces, New Mexico 88005

E-mail Address: rroman@linksoflife.org

Owner: Chandra Baker
E-Mail Address: cbakeruop2004@yahoo.com

Region: Southwest
Routine Survey: February 2 - 9, 2018
Verification Survey: October 1 – 3, 2018

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012 & 2018:** Support Living; Customized Community Supports

Survey Type: Verification

Dear Ms. Roman;

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,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.19.2.DDW.82507511.3.VER.09.18.312