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Date: January 5, 2016

To: William Wagner, Executive Director  
Provider: Community Options, Inc.  
Address: 811 St. Michael Drive, Suite 107  
State/Zip: Santa Fe, New Mexico 87505

E-mail Address: [bill.wagner@comop.org](mailto:bill.wagner@comop.org)

CC: Robert Stack, Chief Executive Officer  
Address: 16 Farber Road  
State/Zip: Princeton, New Jersey 08540

E-Mail Address [robert.stack@comop.org](mailto:robert.stack@comop.org)

Region: Northeast  
Survey Date: October 19 – 22, 2015  
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012:** *Living Supports* (Supported Living, Family Living); *Inclusion Supports* (Customized Community Supports)  
**2007:** *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)

Survey Type: Routine

Team Leader: Leslie Peterson, BBA, MA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Anthony Fragua, BFA, Health Program Manager, Division of Health Improvement/Quality Management Bureau; and Corrina Strain, RN, BSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Wagner:

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

**Determination of Compliance:**

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

***Partial Compliance with Conditions of Participation***

**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>

The following tags are identified as Condition of Participation Level Deficiencies:

- Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation
- Tag # 1A22 Personnel Competency
- Tag # 1A28.1 Incident Mgt. System – Personnel Training

This determination is based on noncompliance with one or more CMS waiver assurances at the Condition of Participation level as well as Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

**Plan of Correction:**

The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

**Submission of your Plan of Correction:**

Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. (See attachment "A" for additional guidance in completing the Plan of Correction).

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

1. **Quality Management Bureau, Attention: Amanda Castaneda, 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**

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

**Billing Deficiencies:**

If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a Void/Adjust claims or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: Julie Ann Hill-Clapp  
HSD/OIG  
Program Integrity Unit  
P.O. Box 2348  
Santa Fe, New Mexico 87504-2348

Or if using UPS, FedEx, DHL (courier mail) send to physical address at:

Attention: Julie Ann Hill-Clapp  
HSD/OIG  
Program Integrity Unit  
2025 S. Pacheco Street

Santa Fe, New Mexico 87505

Please be advised that there is a one-week lag period for applying payments received by check to Voided/Adjusted claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

**Request for Informal Reconsideration of Findings (IRF):**

If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

QMB Deputy Bureau Chief  
5301 Central Ave NE Suite #400  
Albuquerque, NM 87108  
Attention: IRF request

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please 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,

*Leslie Peterson, BBA, MA*

Leslie Peterson, BBA, MA  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date:	October 19, 2015
Present:	<b><u>Community Options, Inc.</u></b> William Wagner, Executive Director Katya Mahurin, Business Manager  <b><u>DOH/DHI/QMB</u></b> Leslie Peterson, BBA, MA, Team Lead/Healthcare Surveyor Anthony Fragua, BFA, Health Program Manager Corrina Strain, RN, BSN, Healthcare Surveyor
Exit Conference Date:	October 22, 2015
Present:	<b><u>Community Options, Inc.</u></b> William Wagner, Executive Director Katya Mahurin, Business Manager  <b><u>DOH/DHI/QMB</u></b> Leslie Peterson, BBA, MA, Team Lead/Healthcare Surveyor Anthony Fragua, BFA, Health Program Manager Corrina Strain, RN, BSN, Healthcare Surveyor  <b><u>DDSD - Northeast Regional Office</u></b> David Naranjo, Intellectual Developmental Disabilities Specialist Angela Pacheco, Northeast Regional Manager
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 10  2 - Jackson Class Members 8 - Non-Jackson Class Members 7 - Supported Living 2 - Family Living 1 - Adult Habilitation 7 - Customized Community Supports
Total Homes Visited	Number: 4
❖ Supported Living Homes Visited	Number: 2  <i>Note: The following Individuals share a SL residence:</i> ➤ # 5, 7, 10 ➤ # 3, 4, 8, 9
❖ Family Living Homes Visited	Number: 2
Persons Served Records Reviewed	Number: 10
Persons Served Interviewed	Number: 8
Persons Served Observed	Number: 2 (1 Individual chose not to be interviewed and 1 Individual was not available during on-site survey)

QMB Report of Findings – Community Options, Inc. – Northeast Region – October 19 – 22, 2015

Survey Report #: Q.16.2.DDW.D3124.2.RTN.01.15.005

Direct Support Personnel Interviewed	Number:	9 (Note: 1 Service Coordinator also performed duties as Direct Support)
Direct Support Personnel Records Reviewed	Number:	20 (Note: 2 additional DSP were interviewed, however DSP personnel records were not provided. Total DSP count was 22)
Substitute Care/Respite Personnel Records Reviewed	Number:	1
Service Coordinator Records Reviewed	Number:	3 (Note: 1 Service Coordinator also performed duties as Direct Support)

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 A

### Provider Instructions for Completing the QMB Plan of Correction (POC) Process

#### **Introduction:**

After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued deficiencies and non-compliance.

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings (Providers who fail to complete a POC within the 45 business days allowed will be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at [AmandaE.Castaneda@state.nm.us](mailto:AmandaE.Castaneda@state.nm.us). Requests for technical assistance must be requested through your Regional DDSD Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

#### **Instructions for Completing Agency POC:**

##### **Required Content**

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

##### **The Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:**

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and

- sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
  6. The POC must be signed and dated by the agency director or other authorized official.

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

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc.;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

**Note: Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps must be taken to ensure the deficiency is corrected and will not recur.

#### **Completion Dates**

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

#### **Initial Submission of the Plan of Correction Requirements**

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at [AmandaE.Castaneda@state.nm.us](mailto:AmandaE.Castaneda@state.nm.us) for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
  - a. Electronically at [AmandaE.Castaneda@state.nm.us](mailto:AmandaE.Castaneda@state.nm.us) (*preferred method*)
  - b. Fax to 575-528-5019, or
  - c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”

- a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
  - b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
  - c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
  - d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
  - e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

### ***POC Document Submission Requirements***

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).
3. All submitted documents must be annotated; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDS Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
  - Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
  - Copies of “void and adjust” forms submitted to Xerox State Healthcare, LLC to correct all unjustified units identified and submitted for payment during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

## Attachment B

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

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and 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 three (3) Service Domains.

#### Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

#### Community Inclusion Supports/ Living Supports:

- Qualified Provider
- Plan of Care
- Health, Welfare and Safety

### 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: Level of Care**

Condition of Participation:

1. **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.

**Service Domain: Plan of Care**

Condition of Participation:

2. **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:

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

**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: Plan of Care**

Condition of Participation:

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

**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:

6. **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.

## 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 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](mailto: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:** Community Options, Inc. – Northeast Region  
**Program:** Developmental Disabilities Waiver  
**Service:** *2012: Living Supports* (Supported Living, Family Living); *Inclusion Supports* (Customized Community Supports)  
*2007: Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)  
**Monitoring Type:** Routine Survey  
**Survey Date:** October 19 – 22, 2015

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
<b>Service Domain: Service Plans: ISP Implementation</b> – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.			
<b>Tag # 1A08</b> <b>Agency Case File</b>	<b>Standard Level Deficiency</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</p> <p><b>Chapter 5 (CIES) 3. Agency Requirements</b></p> <p><b>H. Consumer Records Policy:</b> All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy. Additional documentation that is required to be maintained at the administrative office includes:</p> <ol style="list-style-type: none"> <li>1. Vocational Assessments that are of quality and contain content acceptable to DVR and DDSD;</li> <li>2. Career Development Plans as incorporated in the ISP; and</li> <li>3. Documentation of evidence that services provided under the DDW are not otherwise available under the Rehabilitation Act of 1973 (DVR).</li> </ol> <p><b>Chapter 6 (CCS) 3. Agency Requirements:</b></p> <p><b>G. Consumer Records Policy:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix</p>	<p>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 8 of 10 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• <b>ISP budget forms MAD 046</b> <ul style="list-style-type: none"> <li>◦ Not Current (#4, 5)</li> </ul> </li> <li>• <b>Current Emergency and Personal Identification Information</b> <ul style="list-style-type: none"> <li>◦ Did not contain names and phone numbers of relatives, or guardian or conservator (#7)</li> </ul> </li> <li>• <b>ISP Signature Page</b> <ul style="list-style-type: none"> <li>◦ None Found (#2, 4, 5, 9)</li> <li>◦ Not Fully Constituted IDT (<i>No evidence of the Individual's involvement</i>) (#7)</li> </ul> </li> <li>• <b>ISP Teaching and Support Strategies</b></li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>policy. Additional documentation that is required to be maintained at the administrative office includes:</p> <ol style="list-style-type: none"> <li>1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDS.</li> </ol> <p><b>Chapter 7 (CIHS) 3. Agency Requirements:</b>  <b>E. Consumer Records Policy:</b> All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDS Individual Case File Matrix policy.</p> <p><b>Chapter 11 (FL) 3. Agency Requirements:</b>  <b>D. Consumer Records Policy:</b> All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDS Individual Case File Matrix policy.</p> <p><b>Chapter 12 (SL) 3. Agency Requirements:</b>  <b>D. Consumer Records Policy:</b> All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDS Individual Case File Matrix policy.</p> <p><b>Chapter 13 (IMLS) 2. Service Requirements:</b>  C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items)</p> <ul style="list-style-type: none"> <li>• Emergency contact information;</li> <li>• Personal identification;</li> <li>• ISP budget forms and budget prior authorization;</li> <li>• ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan (PBSP), Behavior Crisis Intervention Plan</li> </ul>	<ul style="list-style-type: none"> <li>◦ <i>Individual # 5 - TSS not found for the following Action Steps:</i></li> <li>◦ Work/Learn Outcome <ul style="list-style-type: none"> <li>◦ "... will work ten hours a week as per his VAP."</li> </ul> </li> <li>◦ <i>Individual #9 - TSS not found for the following Action Steps:</i></li> <li>◦ Live Outcome: <ul style="list-style-type: none"> <li>◦ "... will research freezers to buy."</li> </ul> </li> <li>◦ Work/Learn Outcome: <ul style="list-style-type: none"> <li>◦ "... will explore volunteering and working in his community."</li> </ul> </li> <li>◦ Fun Outcome: <ul style="list-style-type: none"> <li>◦ "... will organize a movie and popcorn night with his housemates."</li> <li>◦ "... will organize fun activities for himself."</li> </ul> </li> </ul> <ul style="list-style-type: none"> <li>• Positive Behavioral Support Plan (#1, 9)</li> <li>• Behavior Crisis Intervention Plan (#8)</li> <li>• Speech Therapy Plan (#10)</li> <li>• Occupational Therapy Plan (#5, 7)</li> <li>• Physical Therapy Plan (#7)</li> <li>• Documentation of Guardianship/Power of Attorney (#2)</li> </ul>		
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<p>(BCIP), or other relevant behavioral plans, Medical Emergency Response Plan (MERP), Healthcare Plan, Comprehensive Aspiration Risk Management Plan (CARMP), and Written Direct Support Instructions (WDSI);</p> <ul style="list-style-type: none"> <li>• Dated and signed evidence that the individual has been informed of agency grievance/complaint procedure at least annually, or upon admission for a short term stay;</li> <li>• Copy of Guardianship or Power of Attorney documents as applicable;</li> <li>• Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays;</li> <li>• Written consent by relevant health decision maker and primary care practitioner for self-administration of medication or assistance with medication from DSP as applicable;</li> <li>• Progress notes written by DSP and nurses;</li> <li>• Signed secondary freedom of choice form;</li> <li>• Transition Plan as applicable for change of provider in past twelve (12) months.</li> </ul> <p><b>DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012</b></p> <p><b>III. Requirement Amendments(s) or Clarifications:</b></p> <p>A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.</p> <p>H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p>			
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**CHAPTER 1 II. PROVIDER AGENCY**

**REQUIREMENTS: D. Provider Agency Case**

**File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:

- (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;
- (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);
- (3) Progress notes and other service delivery documentation;
- (4) Crisis Prevention/Intervention Plans, if there are any for the individual;
- (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;
- (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and
- (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.
- (8) The receiving Provider Agency shall be provided at a minimum the following records

<p>whenever an individual changes provider agencies:</p> <ul style="list-style-type: none"> <li>(a) Complete file for the past 12 months;</li> <li>(b) ISP and quarterly reports from the current and prior ISP year;</li> <li>(c) Intake information from original admission to services; and</li> <li>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</li> </ul> <p><b>NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b> A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.</p> <p><b>B. Documentation of test results:</b> Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.</p>			
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<p><b>Chapter 13 (IMLS) 3. Agency Requirements:</b>  <b>4. Reimbursement A. 1...</b> Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...</p> <p><b>Chapter 15 (ANS) 4. Reimbursement A. 1.</b>  ...Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007  <b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <p>(3) Progress notes and other service delivery documentation;</p>			
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<p>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]</p>	<ul style="list-style-type: none"> <li>• None found regarding: Live Outcome/Action Steps: "... will choose her shirt top" for 7/2015 and 8/2015. Action Step is to be completed 2 times per week.</li> <li>• None found regarding: Live Outcome/Action Steps: "... will choose her pants/skirt bottom" for 7/2015 and 8/2015. Action Step is to be completed 2 times per week.</li> </ul> <p>Individual # 9</p> <ul style="list-style-type: none"> <li>• None found regarding: Live Outcome/Action Steps: "... will research freezers to buy" for 7/2015 – 9/2015. Action Step is to be completed 1 time per month.</li> <li>• None found regarding: Fun Outcome/Action Steps: ".... will organize a movie and popcorn night with his housemates" for 7/2015 - 9/2015. Action Step is to be completed 1 time per month.</li> <li>• None found regarding: Fun Outcome/Action Steps: ".... will organize fun activities for himself" for 7/2015 – 9/2015. Action Step is to be completed 1 time per month.</li> </ul> <p>Individual #10</p> <ul style="list-style-type: none"> <li>• None found regarding: Live Outcome/Action Steps: "... will turn on the vibrating switch" for 8/2015. Action Step is to be completed 1 time per week.</li> <li>• None found regarding: Live Outcome/Action Steps: "... will turn off the vibrating switch" for 8/2015. Action Step is to be completed 1 time per week.</li> <li>• None found regarding: Fun Outcome/Action Steps: "... will build sensory tolerance by</li> </ul>		
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	<p>enjoying smells, tastes and environments and creating new friends” for 8/2015. Action Step is to be completed 1 time per week.</p> <ul style="list-style-type: none"> <li>• None found regarding: Fun Outcome/Action Steps: “... will enjoy a drink once a week” for 8/2015. Action Step is to be completed 1 time per week.</li> </ul> <p><b>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual # 6</p> <ul style="list-style-type: none"> <li>• None found regarding: Live Outcome/Action Step: “... will receive verbal prompts and instructions/modeling on how to complete the tasks of running the washer and dryer without ongoing prompts” for 7/2015 and 8/2015. Action Step is to be completed 1 time per week.</li> </ul> <p><b>Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual # 2</p> <ul style="list-style-type: none"> <li>• None found regarding: Work/Learn Outcome/Action Step: “... will select the day” weekly for 9/2015.</li> <li>• None found regarding: Work/Learn Outcome/Action Step: “... will try new activities” weekly for 9/2015.</li> </ul> <p>Individual # 7</p> <ul style="list-style-type: none"> <li>• None found regarding: Work/Learn Outcome/Action Step: “... will volunteer at the animal shelter” for 8/2015 and 9/2015. Action Step is to be completed 1 time per month.</li> </ul>		
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	<ul style="list-style-type: none"> <li>• None found regarding: Fun Outcome/Action Step: "... will choose an activity based on research" for 8/2015. Action Step is to be completed 1 time per month.</li> <li>• None found regarding: Fun Outcome/Action Step: "... will participate in her selected activity" for 8/2015. Action Step is to be completed 1 time per month.</li> </ul> <p>Individual # 8</p> <ul style="list-style-type: none"> <li>• None found regarding: Work/Learn Outcome/Action Step: "... will volunteer in the community" for 9/2015. Action Step is to be completed 4 - 6 times per month.</li> <li>• None found regarding: Fun Outcome/Action Step: "... will rate outing using a system developed by staff" for 9/2015. Action Step is to be completed 1 time per month.</li> </ul> <p>Individual #9</p> <ul style="list-style-type: none"> <li>• None found regarding: Work/Learn Outcome/Action Step: "... will explore volunteering and working in his community" for 7/2015 – 9/2015. Action Step is to be completed 1 time a week, up to 10 hours per week.</li> </ul> <p><b>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual # 5</p> <ul style="list-style-type: none"> <li>• None found regarding: Work/Learn Outcome/Action Step: "... will job sample possible work environments per his VAP" for 7/2015 – 9/2015. Action Step is to be completed weekly.</li> </ul>		
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	<ul style="list-style-type: none"> <li>• None found regarding: Work/Learn Outcome; Action Step: "... will work ten hours a week as per his VAP" for 7/2015 – 9/2015. Action Step is to be completed weekly.</li> </ul> <p><b>Residential Files Reviewed:</b></p> <p><b>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #3</p> <ul style="list-style-type: none"> <li>• None found regarding: Live Outcome/Action Step: "... will research a different recipe" for 10/1 – 16, 2015. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Live Outcome/Action Step: "... will prepare needed ingredients" for 10/1 – 16, 2015. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Live Outcome/Action Step: "... will prepare items to complete recipe and enjoy" for 10/1 – 16, 2015. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Fun Outcome/Action Step: "... will choose a restaurant or bar using media or her iPad" for 10/1 – 16, 2015. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Fun Outcome/Action Step: "... will choose an outing" for 10/1 - 16, 2015. Action step is to be completed 1 time per week.</li> </ul> <p>Individual #8</p>		
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	<ul style="list-style-type: none"> <li>• None found regarding: Health/Other Outcome/Action Step: "... will choose a physical activity" for 10/1 - 16, 2015. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Health/Other Outcome/Action Step: "...will participate in his chosen activity" for 10/1 - 16, 2015. Action step is to be completed 1 time per week.</li> </ul> <p>Individual #9</p> <ul style="list-style-type: none"> <li>• None found regarding: Live Outcome/Action Step: "... will change sheets on bed" for 10/1 - 16, 2015. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Live Outcome/Action Step: "... will sweep floor in his room" for 10/1 - 16, 2015. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Work Outcome/Action Step: "... will try new activities in the community" for 10/1 - 16, 2015. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Work Outcome/Action Step: "... will try new activities, movies, ball games, throwing Frisbees" for 10/1 - 16, 2015. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Fun Outcome/Action Step: "...will establish a safe route to Wendy's and back home" for 10/1 - 16, 2015. Action step is to be completed 1 time per week.</li> </ul>		
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- None found regarding: Fun Outcome/Action Step: "...will walk to Wendy's and back home" for 10/1 - 16, 2015. Action step is to be completed 5 times per week.

**Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**

Individual #1

- None found for 10/1 - 21, 2015.

Individual #6

- None found for 10/1 - 19, 2015.



<p>hours to the Community Integrated Employment budget);</p> <p>b. Written annual updates to the ISP work/learn action plan to DDSD;</p> <p>2.VAP to the case manager if completed externally to the ISP;</p> <p>3.Initial ISP reflecting the Vocational Assessment or the annual ISP with the updated VAP integrated or a copy of an external VAP if one was completed to DDSD;</p> <p>4.Quarterly Community Integrated Employment Wage and Hour Reports for individuals employed and in job development to DDSD based on the DDSD fiscal year; and</p> <p>a. Data related to the requirements of the Performance Contract to DDSD quarterly.</p> <p><b>CHAPTER 6 (CCS) 3. Agency Requirements:</b>  <b>H. Reporting Requirements:</b> The Customized Community Supports Provider Agency shall submit the following:</p> <p>1.Semi-annual progress reports one hundred ninety (190) days following the date of the annual ISP, and 14 days prior to the annual IDT meeting:</p> <p>a. Identification of and implementation of a Meaningful Day definition for each person served;</p> <p>b. Documentation for each date of service delivery summarizing the following:</p> <p>i.Choice based options offered throughout the day; and</p> <p>ii.Progress toward outcomes using age appropriate strategies specified in each</p>			
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<p>individual's action steps in the ISP, and associated support plans/WDSI.</p> <p>c. Record of personally meaningful community inclusion activities; and</p> <p>d. Written updates, to the ISP Work/Learn Action Plan annually or as necessary due to change in work goals. These updates do not require an IDT meeting unless changes requiring team input need to be made.</p> <p>e. Data related to the requirements of the Performance Contract to DDS quarterly.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>E. Provider Agency Reporting Requirements:</b> All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation:</p> <p>(1) Identification and implementation of a meaningful day definition for each person served;</p> <p>(2) Documentation summarizing the following:</p> <ul style="list-style-type: none"> <li>(a) Daily choice-based options; and</li> <li>(b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP.</li> </ul> <p>(3) Significant changes in the individual's routine or staffing;</p>			
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<p>(4) Unusual or significant life events;  (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;  (6) Record of personally meaningful community inclusion;  (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and  (8) Any additional reporting required by DDSD.</p>			
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<p>short term stays, including any treatment provided;</p> <p>i. Progress notes written by DSP and nurses;</p> <p>j. Documentation and data collection related to ISP implementation;</p> <p>k. Medicaid card;</p> <p>l. Salud membership card or Medicare card as applicable; and</p> <p>m. A Do Not Resuscitate (DNR) document and/or Advanced Directives as applicable.</p> <p><b>DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012</b></p> <p><b>III. Requirement Amendments(s) or Clarifications:</b></p> <p>A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.</p> <p>H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.</p> <p><b>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</b></p> <p><b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>A. Residence Case File:</b> For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:</p>	<ul style="list-style-type: none"> <li>◦ Live Outcome Statement: <ul style="list-style-type: none"> <li>➤ "...will research a different recipe to prepare at home."</li> <li>➤ "...will prepare needed ingredients."</li> <li>➤ "...will prepare items for recipe and enjoy."</li> </ul> </li> <li>◦ Fun Outcome Statement: <ul style="list-style-type: none"> <li>➤ "...will choose a restaurant or bar using media or her iPad once per week."</li> <li>➤ "...will choose an outing once per week."</li> </ul> </li> <li>◦ Individual #5 - TSS not found for the following Action Steps:</li> <li>◦ Fun Outcome Statement: <ul style="list-style-type: none"> <li>➤ "...will identify a time to take a vacation to Carlsbad."</li> <li>➤ "...will help pack for his vacation."</li> <li>➤ "...will go on vacation to Carlsbad."</li> </ul> </li> <li>◦ Individual #9 - TSS not found for the following Action Steps:</li> <li>◦ Live Outcome Statement: <ul style="list-style-type: none"> <li>➤ "...will research freezers to buy."</li> </ul> </li> <li>◦ Work/Learn Outcome Statement: <ul style="list-style-type: none"> <li>➤ "... explore volunteering and working in his community."</li> </ul> </li> <li>◦ Fun Outcome Statement: <ul style="list-style-type: none"> <li>➤ "... organize a movie and popcorn night with his housemates."</li> </ul> </li> </ul>		
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<p>(1) Complete and current ISP and all supplemental plans specific to the individual;</p> <p>(2) Complete and current Health Assessment Tool;</p> <p>(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</p> <p>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ol style="list-style-type: none"> <li>The name of the individual;</li> <li>A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;</li> <li>Diagnosis for which the medication is prescribed;</li> <li>Dosage, frequency and method/route of delivery;</li> <li>Times and dates of delivery;</li> </ol>	<ul style="list-style-type: none"> <li>➤ "... will organize fun activities for himself (go to Shidoni, train ride to ABQ, go to zoo)</li> </ul> <ul style="list-style-type: none"> <li>• Positive Behavioral Plan (#1, 4, 5, 8, 9)</li> <li>• Behavior Crisis Intervention Plan (#4, 5)</li> <li>• Speech Therapy Plan (#8, 9)</li> <li>• Occupational Therapy Plan (#5)</li> <li>• Physical Therapy Plan (#7)</li> <li>• Healthcare Passport (#1, 7, 8, 9)</li> <li>• <b>Progress Notes/Daily Contacts Logs:</b> <ul style="list-style-type: none"> <li>◦ Individual #1 - None found for 10/1 – 21, 2015.</li> <li>◦ Individual #6 - None found for 10/1 – 9, 2015.</li> </ul> </li> </ul>		
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<p>(f) Initials of person administering or assisting with medication; and</p> <p>(g) An explanation of any medication irregularity, allergic reaction or adverse effect.</p> <p>(h) For PRN medication an explanation for the use of the PRN must include:</p> <ul style="list-style-type: none"> <li>(i) Observable signs/symptoms or circumstances in which the medication is to be used, and</li> <li>(ii) Documentation of the effectiveness/result of the PRN delivered.</li> </ul> <p>(i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis.</p> <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and</p> <p>(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.</p>			
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<p>a. Name of individual and date on each page;</p> <p>b. Timely completion of relevant activities from ISP Action Plans;</p> <p>c. Progress towards desired outcomes in the ISP accomplished during the past six month;</p> <p>d. Significant changes in routine or staffing;</p> <p>e. Unusual or significant life events, including significant change of health condition;</p> <p>f. Data reports as determined by IDT members; and</p> <p>g. Signature of the agency staff responsible for preparing the reports.</p> <p><b>CHAPTER 12 (SL) 3. Agency Requirements: E. Living Supports- Supported Living Service Provider Agency Reporting Requirements:</b></p> <p><b>1. Semi-Annual Reports:</b> Supported Living providers must submit written semi-annual status reports to the individual's Case Manager and other IDT Members no later than one hundred ninety (190) calendar days after the ISP effective date. When reports are developed in any other language than English, it is the responsibility of the provider to translate the reports into English. The semi-annual reports must contain the following written documentation:</p> <p>a. Name of individual and date on each page;</p> <p>b. Timely completion of relevant activities from ISP Action Plans;</p>			
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<p>c. Progress towards desired outcomes in the ISP accomplished during the past six (6) months;</p> <p>d. Significant changes in routine or staffing;</p> <p>e. Unusual or significant life events, including significant change of health condition;</p> <p>f. Data reports as determined by IDT members; and</p> <p>g. Signature of the agency staff responsible for preparing the reports.</p> <p><b>CHAPTER 13 (IMLS) 3. Agency Requirements: F. Quality Assurance/Quality Improvement (QA/QI) Program:</b></p> <p>4. Intensive Medical Living Services providers shall submit a written semi-annual (non-nursing) status report to the individual's case manager and other IDT members no later than the one hundred ninetieth (190<sup>th</sup>) day following ISP effective date. These semi-annual status reports shall contain at least the following information:</p> <p>a. Status of completion of ISP Action Plans and associated support plans and/or WDSI;</p> <p>b. Progress towards desired outcomes;</p> <p>c. Significant changes in routine or staffing;</p> <p>d. Unusual or significant life events; and</p> <p>e. Data reports as determined by the IDT members;</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p>			
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<p><b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</b> D. Community Living Service Provider Agency Reporting Requirements: <b>All Community Living Support providers shall submit written quarterly status reports to the individual’s Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation:</b></p> <ul style="list-style-type: none"> <li>(1) Timely completion of relevant activities from ISP Action Plans</li> <li>(2) Progress towards desired outcomes in the ISP accomplished during the quarter;</li> <li>(3) Significant changes in routine or staffing;</li> <li>(4) Unusual or significant life events;</li> <li>(5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and</li> <li>(6) Data reports as determined by IDT members.</li> </ul>			
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<p>program in passenger transportation assistance before assisting any resident. The passenger transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of equipment, familiarity with state regulations governing the transportation of persons with disabilities, and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed.</p> <p><b>(2)</b> Any employee or agent of a regulated facility or agency who drives a motor vehicle provided by the facility or agency for use in the transportation of clients must complete:</p> <p><b>(a)</b> A state approved training program in passenger assistance and</p> <p><b>(b)</b> A state approved training program in the operation of a motor vehicle to transport clients of a regulated facility or agency. The motor vehicle transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of motor vehicles, familiarity with state regulations governing the transportation of persons with disabilities, maintenance and safety record keeping, training on hazardous driving conditions and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed.</p> <p><b>(c)</b> A valid New Mexico driver's license for the type of vehicle being operated consistent with State of New Mexico requirements.</p> <p><b>(3)</b> Each regulated facility and agency shall establish and enforce written policies (including training) and procedures for employees who provide assistance to clients with boarding or alighting from motor vehicles.</p> <p><b>(4)</b> Each regulated facility and agency shall establish and enforce written policies (including</p>			
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<p>training and procedures for employees who operate motor vehicles to transport clients.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013  <b>CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements:</b> 1. All Community Inclusion Providers must provide staff training in accordance with the DDS policy T-003: Training Requirements for Direct Service Agency Staff Policy.</p> <p><b>CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:</b> 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDS Policy T-003: Training Requirements for Direct Service Agency Staff Policy;</p> <p><b>CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:</b> The Provider Agency must report required personnel training status to the DDS Statewide Training Database as specified in the DDS Policy T-001: Reporting and Documentation of DDS Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDS Policy T-003: Training Requirements for Direct Service Agency Staff Policy</p> <p><b>CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:</b>  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 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</p>			
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<p>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.</p> <p><b>CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:</b>  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>CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.</b> 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 Statewide Training Database as specified in the DDS Policy T-001: Reporting and Documentation of DDS Training Requirements Policy;</p>			
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<p>employment and before working alone with an individual receiving service.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013  <b>CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements:</b> 1. All Community Inclusion Providers must provide staff training in accordance with the DDS policy T-003: Training Requirements for Direct Service Agency Staff Policy.</p> <p><b>CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:</b> 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDS Policy T-003: Training Requirements for Direct Service Agency Staff Policy;</p> <p><b>CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:</b> The Provider Agency must report required personnel training status to the DDS Statewide Training Database as specified in the DDS Policy T-001: Reporting and Documentation of DDS Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDS Policy T-003: Training Requirements for Direct Service Agency Staff Policy</p> <p><b>CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:</b>  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 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</p>			
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<p>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.</p> <p><b>CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:</b>  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>CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.</b> 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 Statewide Training Database as specified in the DDS Policy T-001: Reporting and Documentation of DDS Training Requirements Policy;</p>			
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<p>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><b>CHAPTER 11 (FL) 3. Agency Requirements</b>  <b>B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:</b>  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 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 DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.</p>	<ul style="list-style-type: none"> <li>• DSP #210 stated, “Yes, but I don’t know what the plan covers.” According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #3)</li> <li>• DSP #210 stated, “I think so yeah, but I don’t know what the plan covers.” According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #8)</li> <li>• DSP #209 stated, “...have talked about it, but don’t know if I was trained. ” According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #9)</li> </ul> <p><b>When DSP were asked if the individual had a Behavioral Crisis Intervention Plan and if so, what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #210 stated, “Yes, but I don’t know what the plan covers.” According to the Individual Specific Training Section of the ISP, the individual has Behavioral Crisis Intervention Plan. (Individual #3)</li> <li>• DSP #210 stated, “Yes, give him space.” However, according to the Individual Specific Training Section of the ISP the individual <b>does not</b> require a Positive Behavioral Crisis Plan. (Individual #8)</li> </ul> <p><b>When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #210 stated, “Yes, but I don’t know what the plan covers. I haven’t gotten to that part.”</li> </ul>		
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<p>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.</p> <p><b>CHAPTER 12 (SL) 3. Agency Requirements</b>  <b>B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:</b>  A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD 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 DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.  B Individual specific training must be arranged and conducted, including training on the ISP</p>	<p>According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #3)</p> <ul style="list-style-type: none"> <li>• DSP #210 stated, “Yes, but I don’t know what the plan covers.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #8)</li> </ul> <p><b>When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #210 stated, “I think so, but I haven’t had a training for that either.” According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #3)</li> <li>• DSP #210 stated, “Yes, but I still don’t know nothing about that one.” However, according to the Individual Specific Training Section of the ISP the Individual <b>does not</b> require an Occupational Therapy Plan. (Individual #8)</li> </ul> <p><b>When DSP were asked if the Individual had a Physical Therapy Plan and if so, what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #210 stated, “Yes, but haven’t had a training.” According to the Individual Specific Training Section of the, the Individual requires a Physical Therapy Plan. (Individual #3)</li> <li>• DSP #210 stated, “Yes, but I don’t know, I get so confused.” According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #8)</li> </ul>		
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<p>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><b>CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.</b> E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. 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;</p>	<p><b>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #210 stated, “I haven’t got trained on those either.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Aspiration, Seizures, Constipation, Bowel and Bladder, Skin and Wound. (Individual #3)</li> <li>• DSP #209 stated, “No.” As indicated by the Agency file, the Individual has Health Care Plans for Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Body Mass Index, Status of Care Hygiene, Seizures, Endocrine with Diabetes, A1C Levels, and Pain. (Individual #4)</li> <li>• DSP #210 stated, “For his Diabetes, that’s all I know.” As indicated by the Agency file, Osteopenia and as indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Body Mass Index, Aspiration Risk, Seizure disorder, Respiratory, Falls, Pain. (Individual #8)</li> <li>• DSP #209 stated, “I don’t think so.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Status of care Hygiene, Seizure Disorder. (Individual #9)</li> </ul> <p><b>When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:</b></p>	
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- DSP #210 stated, “I don’t think she has any of those.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for: Aspiration and Seizure Disorder. (Individual #3)
- DSP #209 stated, “I don’t think so.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for: Seizure Disorder, Endocrine with Diabetes, and A1C Levels. (Individual #4)
- DSP #210 stated, “I don’t know.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for: Aspiration Risk, Seizure Disorder, Endocrine, Respiratory, Falls, and Pain. (Individual #8)
- DSP #209 stated, “I don’t think so.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for: Seizure Disorder. (Individual #9)

**When DSP were asked if the Individual had a Seizure Disorder, the following was reported:**

- DSP #210 stated, “He should yes, I believe in his book, but haven’t been trained yet.” As indicated by the Individual Specific Training section of the ISP (residential) staff are required to receive training on seizures. (Individual #8)
- DSP #209 stated, “I don’t think so.” As indicated by the Individual Specific Training section of the ISP (residential) staff are

	<p>required to receive training on seizures. (Individual #4)</p> <ul style="list-style-type: none"> <li>• DSP #209 stated, "I don't remember if I received training." As indicated by the Individual Specific Training section of the ISP (residential) staff are required to receive training on seizures. (Individual #9)</li> </ul> <p><b>When DSP were asked if they assisted the individual with medications and had received the Assisting with Medications (AWM) training, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #210 stated, "I still have some training to do. I'm still getting help." (Individual #3)</li> <li>• DSP #210 stated, "I still have some training to do. I'm still getting help." (Individual #8)</li> </ul> <p><b>When DSP were asked what the individual's Diagnosis were, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #210 stated, "I'm not sure." According to the individual's Medication Administration Record the individual is diagnosed with Brain Injury, Gastroesophageal Reflux Disease and Depression and Allergic Rhinitis. Staff did not discuss the listed diagnosis. (Individual #3)</li> <li>• DSP #204 searched the residential file for an extended period of time but was unable to answer. According to the individual's Medication Administration Record the individual is diagnosed with Seizures, Encephalitis, Depression, Hypothyroidism, Hypertension, Mental Retardation and Osteoarthritis. Staff did not discuss the listed diagnosis. (Individual #7)</li> </ul>		
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- DSP #210 stated, “Diabetic, sugar issues, that’s the only thing I know.” According to the individual’s Medication Administration Record the individual is diagnosed with Leukocytopenia Seizures, Anemia Developmental Delay and Pallister Mosaic Syndrome. Staff did not discuss the listed diagnosis. (Individual #8)

- DSP #204 searched the residential file for an extended period of time and did not discuss any diagnosis. According to the individuals Medication Administration Record the individual is diagnosed with Mental Retardation Hypothyroidism, Night Blindness, Depressive Disorder, Gastroesophageal Reflux Disease, and Osteopenia. (Individual #10)

**When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was reported:**

- DSP #210 stated, “No.” As indicated by the Electronic Comprehensive Health Assessment Tool the individual is allergic to Lamictal. (Individual #3)
- DSP #209 stated, “No.” As indicated by the Electronic Comprehensive Health Assessment Tool the individual is allergic to Aspirin and Phenobarbital. (individual #9)



<p>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.</p> <p>E. <b>Documentation for other staff.</b> 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.</p> <p>F. <b>Consequences of noncompliance.</b> 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.</p>			
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Tag # 1A28.1 Incident Mgt. System - Personnel Training	Condition of Participation Level Deficiency		
<p><b>NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS</b></p> <p><b>NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner.</p> <p><b>B. Training curriculum:</b> Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer.</p> <p><b>C. Incident management system training curriculum requirements:</b></p>	<p>After an analysis of the evidence it has been determined the following there is a significant potential for a negative outcome to occur.</p> <p>Based on record review and interview, the Agency did not ensure Incident Management Training for 10 of 25 Agency Personnel.</p> <p><b>Direct Support Personnel (DSP):</b></p> <ul style="list-style-type: none"> <li>Incident Management Training (Abuse, Neglect and Exploitation) (DSP# 201, 214, 215, 216, 218)</li> </ul> <p><b>Service Coordination Personnel (SC):</b></p> <ul style="list-style-type: none"> <li>Incident Management Training (Abuse, Neglect and Exploitation) (SC #224)</li> </ul> <p><b>When Direct Support Personnel were asked what State Agency must be contacted when there is suspected Abuse, Neglect and Exploitation, the following was reported:</b></p> <ul style="list-style-type: none"> <li>DSP #200 stated, "I don't know." Staff was not able to identify the State Agency as Division of Health Improvement.</li> <li>DSP #210 stated, "Community Options would just call the cops." Staff was not able to identify the State Agency as Division of Health Improvement.</li> <li>DSP #213 stated, "I don't know." Staff was not able to identify the State Agency as Division of Health Improvement.</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>(1) The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to:</p> <ul style="list-style-type: none"> <li>(a) an overview of the potential risk of abuse, neglect, or exploitation;</li> <li>(b) informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form;</li> <li>(c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths;</li> <li>(d) specific instructions on how to respond to abuse, neglect, or exploitation;</li> <li>(e) Emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury.</li> </ul> <p>(2) All current employees and volunteers shall receive training within 90 days of the effective date of this rule.</p> <p>(3) All new employees and volunteers shall receive training prior to providing services to consumers.</p> <p><b>D. Training documentation:</b> All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be</p>	<p><b>When DSP were asked to give examples of Abuse, Neglect and Exploitation, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #210 stated, "Abuse is hitting, Neglect is just bruises everywhere and Exploitation, just getting that word, don't know."</li> <li>• DSP #204 stated, "I guess I don't know what exploitation means."</li> </ul>		
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<p>made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule.</p> <p><b>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p>			
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<p><b>Chapter 5 (CIES) 3. Agency Requirements</b>  <b>H. Consumer Records Policy:</b> All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy.</p> <p><b>Chapter 6 (CCS) 3. Agency Requirements:</b>  <b>G. Consumer Records Policy:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p><b>Chapter 7 (CIHS) 3. Agency Requirements:</b>  <b>E. Consumer Records Policy:</b> All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p><b>Chapter 11 (FL) 3. Agency Requirements:</b>  <b>D. Consumer Records Policy:</b> All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p><b>Chapter 12 (SL) 3. Agency Requirements:</b>  <b>D. Consumer Records Policy:</b> All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p>	<p>be conducted annually. No evidence of current exam was found.</p> <ul style="list-style-type: none"> <li>Individual #9 - As indicated by collateral documentation reviewed, the exam was attempted on 5/14/2014. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found.</li> </ul> <p><b>Vision Exam</b></p> <ul style="list-style-type: none"> <li>Individual #1 – As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. Per nursing note on 8/11/2015, vision exam was attempted but an adequate test could not be completed. No evidence of exam was found.</li> <li>Individual #9 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.</li> </ul> <p><b>Auditory Exam</b></p> <ul style="list-style-type: none"> <li>Individual #8 - As indicated by collateral documentation reviewed, exam was completed on 9/29/2014. Follow-up was to be completed in 1 year. No evidence of follow-up found.</li> </ul> <p><b>Bone Density Exam</b></p> <ul style="list-style-type: none"> <li>Individual #8 - As indicated by collateral documentation reviewed, exam was scheduled for 7/17/2015. No evidence of exam results were found.</li> </ul> <p><b>Cholesterol and Blood Glucose</b></p> <ul style="list-style-type: none"> <li>Individual #9 - As indicated by collateral documentation reviewed, lab work was</li> </ul>		
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<p><b>Chapter 13 (IMLS) 2. Service Requirements:</b> C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items)...</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p><b>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</b></p> <p><b>G. Health Care Requirements for Community Living Services.</b></p> <p>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the</p>	<p>completed on 3/6/2014. No evidence of lab results were found.</p> <p><b>Blood Levels</b></p> <ul style="list-style-type: none"> <li>Individual #9 - As indicated by collateral documentation reviewed, lab work for CBC, CMP and TSH was completed on 3/6/2014. No evidence of lab results were found.</li> </ul>		
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<p>individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first.</p> <p>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <ul style="list-style-type: none"> <li>(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</li> <li>b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.</li> <li>(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.</li> </ul>			
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<p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <ul style="list-style-type: none"> <li>(a) The individual has a primary licensed physician;</li> <li>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</li> <li>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</li> <li>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</li> <li>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</li> </ul>			
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<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</p> <p><b>CHAPTER 5 (CIES) 3. Agency Requirements:</b></p> <p><b>J. Quality Assurance/Quality Improvement (QA/QI) Program:</b> 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> <p><b>1. Development of a QA/QI plan:</b> 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><b>2. Implementing a QA/QI Committee:</b> The QA/QI committee must convene on at least a quarterly basis 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 must be documented. The QA/QI review should address at least the following:</p> <p><b>a. Implementation of ISPs:</b> extent to which services are delivered in accordance with ISPs and associated support plans with WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as</p>			
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<p>effectiveness of such implementation as indicated by achievement of outcomes;</p> <p>3. The Provider Agency must complete a QA/QI report annually by February 15<sup>th</sup> of each calendar 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> <ul style="list-style-type: none"> <li>a. Analysis of General Events Reports data in Therap;</li> <li>b. Compliance with Caregivers Criminal History Screening requirements;</li> <li>c. Compliance with Employee Abuse Registry requirements;</li> <li>d. Compliance with DDS training requirements;</li> <li>e. Patterns of reportable incidents;</li> <li>f. Results of improvement actions taken in previous quarters;</li> <li>g. Sufficiency of staff coverage;</li> <li>h. Effectiveness and timeliness of implementation of ISPs, and associated support including trends in achievement of individual desired outcomes;</li> <li>i. Results of General Events Reporting data analysis;</li> <li>j. Action taken regarding individual grievances;</li> <li>k. Presence and completeness of required documentation;</li> <li>l. A description of how data collected as part of the agency's QA/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 QA/QI process; and</li> <li>m. Significant program changes.</li> </ul>			
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<p><b>CHAPTER 6 (CCS) 3. Agency Requirements:</b></p> <p><b>I. Quality Assurance/Quality Improvement (QA/QI) Program:</b> 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><b>1. Development of a QI plan:</b> 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><b>2. Implementing a QI Committee:</b> 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> <p>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</p>			
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<p>implementation as indicated by achievement of outcomes;</p> <ul style="list-style-type: none"> <li>b. Analysis of General Events Reports data;</li> <li>c. Compliance with Caregivers Criminal History Screening requirements;</li> <li>d. Compliance with Employee Abuse Registry requirements;</li> <li>e. Compliance with DDS training requirements;</li> <li>f. Patterns of reportable incidents; and</li> <li>g. Results of improvement actions taken in previous quarters.</li> </ul> <p>3. The Provider Agencies must complete a QA/QI report annually by February 15<sup>th</sup> 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 DDS the report must be submitted to the relevant DDS Regional Offices. The report will summarize:</p> <ul style="list-style-type: none"> <li>a. Sufficiency of staff coverage;</li> <li>b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes;</li> <li>c. Results of General Events Reporting data analysis;</li> <li>d. Action taken regarding individual grievances;</li> <li>e. Presence and completeness of required documentation;</li> <li>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</li> <li>g. Significant program changes.</li> </ul>			
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<p><b>CHAPTER 7 (CIHS) 3. Agency Requirements:</b></p> <p><b>G. Quality Assurance/Quality Improvement (QA/QI) Program:</b> 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> <p>1. <b>Development of a QA/QI plan:</b> 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. <b>Implementing a QA/QI Committee:</b> The QA/QI committee shall 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> <p>a. <b>Implementation of ISPs:</b> The extent to which services are delivered in accordance with ISPs and associated support plans and/or WDSI including the type, scope, amount, duration and frequency specified in</p>			
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<p>the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;</p> <p>b. Analysis of General Events Reports data;</p> <p>c. Compliance with Caregivers Criminal History Screening requirements;</p> <p>d. Compliance with Employee Abuse Registry requirements;</p> <p>e. Compliance with DDS training requirements;</p> <p>f. Patterns of reportable incidents; and</p> <p>g. Results of improvement actions taken in previous quarters.</p> <p>3. The Provider Agency must complete a QA/QI report annually by February 15<sup>th</sup> of each calendar year, or as otherwise request 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> <p>a. Sufficiency of staff coverage;</p> <p>b. Effectiveness and timeliness of implementation of ISPs and associated support plans and/or WDSI, including trends in achievement of individual desired outcomes;</p> <p>c. Results of General Events Reporting data analysis;</p> <p>d. Action taken regarding individual grievances;</p>			
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<p>e. Presence and completeness of required documentation;</p> <p>f. A description of how data collected as part of the agency's QA/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</p> <p>g. Significant program changes.</p> <p><b>CHAPTER 11 (FL) 3. Agency Requirements:</b>  <b>H. Quality Improvement/Quality Assurance (QA/QI) Program:</b> Family 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> <p>1. <b>Development of a QA/QI plan:</b> 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>			
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<p><b>2. Implementing a QA/QI Committee:</b> 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> <ul style="list-style-type: none"> <li>a. 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;</li> <li>b. Analysis of General Events Reports data;</li> <li>c. Compliance with Caregivers Criminal History Screening requirements;</li> <li>d. Compliance with Employee Abuse Registry requirements;</li> <li>e. Compliance with DDS training requirements;</li> <li>f. Patterns in reportable incidents; and</li> <li>g. Results of improvement actions taken in previous quarters.</li> </ul> <p>3. The Provider Agency must complete a QA/QI report annually by February 15<sup>th</sup> 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 DDS; the report must be submitted to the relevant DDS Regional Offices. The report will summarize:</p> <ul style="list-style-type: none"> <li>a. Sufficiency of staff coverage;</li> <li>b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes;</li> <li>c. Results of General Events Reporting data analysis, Trends in category II significant events;</li> </ul>			
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<p>d. Patterns in medication errors;</p> <p>e. Action taken regarding individual grievances;</p> <p>f. Presence and completeness of required documentation;</p> <p>g. A description of how data collected as part of the agency’s QI plan was used;</p> <p>h. 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</p> <p>i. Significant program changes.</p> <p><b>CHAPTER 12 (SL) 3. Agency Requirements:</b>  <b>B. Quality Assurance/Quality Improvement (QA/QI) Program:</b> 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> <p>1. <b>Development of a QA/QI plan:</b> 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>			
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<p><b>2. Implementing a QA/QI Committee:</b> 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> <ul style="list-style-type: none"> <li>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;</li> <li>b. Analysis of General Events Reports data;</li> <li>c. Compliance with Caregivers Criminal History Screening requirements;</li> <li>d. Compliance with Employee Abuse Registry requirements;</li> <li>e. Compliance with DDSD training requirements;</li> <li>f. Patterns in reportable incidents; and</li> <li>g. Results of improvement actions taken in previous quarters.</li> </ul> <p>2. The Provider Agency must complete a QA/QI report annually by February 15<sup>th</sup> of each calendar 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"> <li>a. Sufficiency of staff coverage;</li> <li>b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes;</li> </ul>			
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<p>c. Results of General Events Reporting data analysis, Trends in Category II significant events;</p> <p>d. Patterns in medication errors;</p> <p>e. Action taken regarding individual grievances;</p> <p>f. Presence and completeness of required documentation;</p> <p>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</p> <p>h. Significant program changes.</p> <p><b>CHAPTER 13 (IMLS) 3. Service Requirements: F. Quality Assurance/Quality Improvement (QA/QI) Program:</b> 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><b>1. Development of a QI plan:</b> 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</p>			
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<p>services and methods to evaluate whether implementation of improvements are working.</p> <p><b>2. Implementing a QA/QI Committee:</b> The QA/QI committee shall convene on at least on a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality improvement. For Intensive Medical Living providers, at least one nurse shall be a member of this committee. The QA meeting shall be documented. The QA review should address at least the following:</p> <ul style="list-style-type: none"> <li>a. Implementation of the ISPs, including the extent to which services are delivered in accordance with the ISPs and associated support plans and /or WDSI including the type, scope, amount, duration, and frequency specified in the ISPs as well as effectiveness of such implementation as indicated by achievement of outcomes;</li> <li>b. Trends in General Events as defined by DDSD;</li> <li>c. Compliance with Caregivers Criminal History Screening Requirements;</li> <li>d. Compliance with DDSD training requirements;</li> <li>e. Trends in reportable incidents; and</li> <li>f. Results of improvement actions taken in previous quarters.</li> </ul> <p><b>3. The Provider Agency must complete a QA/QI report annually by February 15<sup>th</sup> of each calendar 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:</b></p> <ul style="list-style-type: none"> <li>a. Sufficiency of staff coverage;</li> <li>b. Effectiveness and timeliness of implementation of ISPs and associated</li> </ul>			
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<p>Support plans and/or WDSI including trends in achievement of individual desired outcomes;</p> <ul style="list-style-type: none"> <li>c. Trends in reportable incidents;</li> <li>d. Trends in medication errors;</li> <li>e. Action taken regarding individual grievances;</li> <li>f. Presence and completeness of required documentation;</li> <li>g. How data collected as part of the agency's QA/QI 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</li> <li>h. Significant program changes.</li> </ul> <p><b>CHAPTER 14 (ANS) 3. Service Requirements: N. Quality Assurance/Quality Improvement (QA/QI) Program:</b> 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. <b>Development of a QI plan:</b> 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</p>			
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<p>services and methods to evaluate whether implementation of improvements are working.</p> <p><b>2. Implementing a QA/QI Committee:</b> The QA/QI committee shall convene on at least on a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality improvement. For Intensive Medical Living providers, at least one nurse shall be a member of this committee. The QA meeting shall be documented. The QA review should address at least the following:</p> <ol style="list-style-type: none"> <li>a. Trends in General Events as defined by DDS;D</li> <li>b. Compliance with Caregivers Criminal History Screening Requirements;</li> <li>c. Compliance with DDS training requirements;</li> <li>d. Trends in reportable incidents; and</li> <li>e. Results of improvement actions taken in previous quarters.</li> </ol> <p>3. The Provider Agency must complete a QA/QI report annually by February 15<sup>th</sup> of each calendar 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;D; the report must be submitted to the relevant DDS Regional Offices. The report will summarize:</p> <ol style="list-style-type: none"> <li>a. Sufficiency of staff coverage;</li> <li>b. Trends in reportable incidents;</li> <li>c. Trends in medication errors;</li> <li>d. Action taken regarding individual grievances;</li> <li>e. Presence and completeness of required documentation;</li> <li>f. How data collected as part of the agency's QA/QI was used, what quality improvement initiatives were undertaken, and what were the results of those efforts, including</li> </ol>			
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<p>discovery and remediation of any service delivery deficiencies discovered through the QI process; and</p> <p>g. Significant program changes</p> <p><b>NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:</b></p> <p><b>F. Quality assurance/quality improvement program for community-based service providers:</b> The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program:</p> <p><b>(1)</b> community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements;</p> <p><b>(2)</b> community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and</p> <p><b>(3)</b> community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.</p>			
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<p>a. Describe your agency's arrangements for on-call nursing coverage to comply with PRN aspects of the DDSD Medication Assessment and Delivery Policy and Procedure as well as response to individuals changing condition/unanticipated health related events;</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</p> <p><b>Chapter 11 (FL) 2. Service Requirement I. Health Care Requirements for Family Living:</b>  <b>9.</b> Family Living Provider Agencies are required to be an Adult Nursing provider and have a Registered Nurse (RN) licensed by the State of New Mexico on staff and residing in New Mexico or bordering towns see: Adult Nursing requirements. The agency nurse may be an employee or a sub-contractor. b. On-call nursing services: An on-call nurse must be available to surrogate or host families DSP for medication oversight. It is expected that no single nurse carry the full burden of on-call duties for the agency.</p> <p><b>Chapter 12 (SL) 2. Service Requirements L. Training Requirements. 6. Nursing Requirements and Roles:</b> d. On-call nursing services: An on-call nurse must be available to DSP during the periods when a nurse is not present. The on-call nurse must be able to make an on-site visit when information provided by DSP over the phone indicate, in the nurse's professional judgment, a need for a face to face assessment to determine appropriate action. An LPN taking on-call must have access to their RN supervisor by phone during their on-call shift in case consultation is required. It is expected that no single nurse carry the full burden of on-call duties for the agency and that nurses be</p>			
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<p>appropriately compensated for taking their turn covering on-call shifts.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1. II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>B. Provider Agency Policy and Procedure Requirements:</b> All Provider Agencies, in addition to requirements under each specific service standard shall at a minimum develop, implement and maintain, at the designated Provider Agency main office, documentation of policies and procedures for the following:</p> <ol style="list-style-type: none"> <li>(1) Coordination of Provider Agency staff serving individuals within the program which delineates the specific roles of agency staff, including expectations for coordination with interdisciplinary team members who do not work for the provider agency;</li> <li>(2) Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated; and</li> <li>(3) Agency protocols for disaster planning and emergency preparedness.</li> </ol>			
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<p>➤ the exact amount to be used in a 24 hour period.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</p> <p><b>CHAPTER 5 (CIES) 1. Scope of Service B. Self Employment 8.</b> Providing assistance with medication delivery as outlined in the ISP; <b>C. Individual Community Integrated Employment 3.</b> Providing assistance with medication delivery as outlined in the ISP; <b>D. Group Community Integrated Employment 4.</b> Providing assistance with medication delivery as outlined in the ISP; and</p> <p><b>B. Community Integrated Employment Agency Staffing Requirements: o.</b> Comply with DDSD Medication Assessment and Delivery Policy and Procedures;</p> <p><b>CHAPTER 6 (CCS) 1. Scope of Services A. Individualized Customized Community Supports 19.</b> Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. <b>C. Small Group Customized Community Supports 19.</b> Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. <b>D. Group Customized Community Supports 19.</b> Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy.</p> <p><b>CHAPTER 11 (FL) 1 SCOPE OF SERVICES A. Living Supports- Family Living Services:</b> The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT):</p> <p><b>19.</b> Assisting in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy,</p>	<ul style="list-style-type: none"> <li>• Cranberry Fruit 405mg capsule (2 times daily) – Blank 10/19 (8 AM)</li> <li>• Docusate Sodium 50mg/5ml liquid (2 times daily) – Blank 10/19 (8 AM)</li> <li>• Bupropion HCL SR F/C 150mg Tablet ER (1 time daily) – Blank 10/19 (8 AM)</li> <li>• Citalopram HBR 20mg Tablet (1 time daily) – Blank 10/19 (8 AM)</li> <li>• Dasetta 1mg – 35mcg Tablet (1 time daily) - Blank 10/19 (8 AM)</li> </ul> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Dasetta 1mg – 35mcg Tablet (1 time daily)</li> </ul> <p>Individual #4 October 2015</p> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Victoza 3-pack 0.6 mg/0.1ml (1 time daily) – Blank 10/17, 18 (8 AM)</li> <li>• Aripiprazole 10mg (1 time daily) – Blank 10/17, 18 (8AM)</li> </ul> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Aripiprazole 10mg (1 time daily)</li> </ul> <p>Individual #5 September 2015</p>		
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<p>New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and</p> <p><b>I. Healthcare Requirements for Family Living.</b></p> <p><b>3. B. Adult Nursing Services</b> for medication oversight are required for all surrogate Lining Supports- Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication.</p> <p><b>6. Support Living- Family Living Provider Agencies</b> must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations.</p> <p>a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;</p> <p>b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:</p> <p>i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;</p>	<p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Lorazepam 0.5mg (1 time daily) – Blank 9/13 (7 PM)</li> </ul> <p>Individual #8 October 2015</p> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Bydureon Latex-Free 2mg vial (1 time weekly) – Blank 10/13 (8 AM)</li> </ul>		
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<p>ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>iii. Initials of the individual administering or assisting with the medication delivery;</p> <p>iv. Explanation of any medication error;</p> <p>v. Documentation of any allergic reaction or adverse medication effect; and</p> <p>vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>c. The Family Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and</p> <p>d. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications.</p> <p>e. Medication Oversight is optional if the individual resides with their biological family (by affinity or consanguinity). If Medication Oversight is not selected as an Ongoing Nursing Service, all elements of medication administration and oversight are the sole responsibility of the individual and their biological family. Therefore, a monthly medication administration record (MAR) is not required unless the family requests it and continually communicates all medication changes to the provider agency in a timely manner to insure accuracy of the MAR.</p>			
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<p>i. The family must communicate at least annually and as needed for significant change of condition with the agency nurse regarding the current medications and the individual's response to medications for purpose of accurately completing required nursing assessments.</p> <p>ii. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not deliver medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a Certified Medication Aide (CMA). Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements.</p> <p>iii. If the substitute care provider is a surrogate (not related by affinity or consanguinity) Medication Oversight must be selected and provided.</p> <p><b>CHAPTER 12 (SL) 2. Service Requirements L. Training and Requirements: 3. Medication Delivery:</b> Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.</p> <p>h. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;</p>			
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<p>i. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:</p> <ul style="list-style-type: none"> <li>i. The name of the individual, a transcription of the physician’s or licensed health care provider’s prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;</li> <li>ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;</li> <li>iii. Initials of the individual administering or assisting with the medication delivery;</li> <li>iv. Explanation of any medication error;</li> <li>v. Documentation of any allergic reaction or adverse medication effect; and</li> <li>vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</li> </ul> <p>j. The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and</p> <p>k. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service</p>			
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locations and must include the expected desired outcomes of administrating the medication, signs, and symptoms of adverse events and interactions with other medications.

**CHAPTER 13 (IMLS) 2. Service**

**Requirements. B.** There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007

**CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:**

**E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.

(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:

- (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication,

<p>diagnosis for which the medication is prescribed;</p> <ul style="list-style-type: none"> <li>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</li> <li>(c) Initials of the individual administering or assisting with the medication;</li> <li>(d) Explanation of any medication irregularity;</li> <li>(e) Documentation of any allergic reaction or adverse medication effect; and</li> <li>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</li> </ul> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p>			
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<b>Tag # 1A09.1</b> <b>Medication Delivery</b> <b>PRN Medication Administration</b>	<b>Standard Level Deficiency</b>		
<p><b>NMAC 16.19.11.8 MINIMUM STANDARDS:</b>  <b>A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</b>  (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, <b>including over-the-counter medications.</b>  This documentation shall include:</p> <ul style="list-style-type: none"> <li>(i) Name of resident;</li> <li>(ii) Date given;</li> <li>(iii) Drug product name;</li> <li>(iv) Dosage and form;</li> <li>(v) Strength of drug;</li> <li>(vi) Route of administration;</li> <li>(vii) How often medication is to be taken;</li> <li>(viii) Time taken and staff initials;</li> <li>(ix) Dates when the medication is discontinued or changed;</li> <li>(x) The name and initials of all staff administering medications.</li> </ul> <p><b>Model Custodial Procedure Manual</b>  <b>D. Administration of Drugs</b>  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.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> <li>➤ symptoms that indicate the use of the medication,</li> <li>➤ exact dosage to be used, and</li> </ul>	<p>Medication Administration Records (MAR) were reviewed for the months of September and October, 2015.</p> <p>Based on record review, 4 of 7 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:</p> <p>Individual #3  October 2015  No evidence of documented Signs/Symptoms were found for the following PRN medication:  • Patanol 0.1% drops – PRN – 10/6, 7, 8, 18 (given 1 time)</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:  • Patanol 0.1% drops – PRN – 10/6, 7, 8, 18 (given 1 time)</p> <p>Individual #4  October 2015  No evidence of documented Signs/Symptoms were found for the following PRN medication:  • Diphenhydramine HCL 25mg – PRN – 10/8 (given 1 time)</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:  • Diphenhydramine HCL 25mg – PRN – 10/8 (given 1 time)</p> <p>Individual #5  September 2015</p>	<p><b>Provider:</b>  State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b>  Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>➤ the exact amount to be used in a 24 hour period.</p> <p><b>Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006</b></p> <p><b>F. PRN Medication</b></p> <p>3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.</p> <p>4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).</p> <p><b>H. Agency Nurse Monitoring</b></p> <p>1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications.</p>	<p>No evidence of documented Signs/Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Ketoconazole 2% cream – PRN – 9/3, 6, 7, 10, 14, 17, 21, 24, 28 (given 1 time)</li> </ul> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Ketoconazole 2% cream – PRN – 9/3, 6, 7, 10, 14, 17, 21, 24, 28 (given 1 time)</li> </ul> <p>October 2015</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Ketoconazole 2% cream – PRN – 10/1; (given 1 time), 10/2, 3 (given 2 times), 10/4, 9, 10, 16, 17, 18 (given 1 time)</li> </ul> <p>Individual #10</p> <p>October 2015</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Mapap Acetaminophen 325mg – PRN – 10/8 (given 1 time)</li> </ul>		
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<p>The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication.</p> <p><b>Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:</b>  <b>Medication Assessment and Delivery Procedure Eff Date: November 1, 2006</b>  C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).</p>			
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<p>a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.</p> <p>4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</p> <p><b>CHAPTER 11 (FL) 1 SCOPE OF SERVICES</b>  <b>A. Living Supports- Family Living Services:</b>  The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT):  <b>19.</b> Assisting in medication delivery, and related monitoring, in accordance with the DDS's Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and  <b>I. Healthcare Requirements for Family Living.</b>  <b>3. B.</b> Adult Nursing Services for medication oversight are required for all surrogate Lining Supports- Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication.  <b>6.</b> Support Living- Family Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDS Medication Assessment</p>			
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<p>and Delivery Policy and Procedures, the New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations.</p> <p>f. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;</p> <p>g. When required by the DDS Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:</p> <ul style="list-style-type: none"> <li>i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;</li> <li>ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;</li> <li>iii. Initials of the individual administering or assisting with the medication delivery;</li> <li>iv. Explanation of any medication error;</li> <li>v. Documentation of any allergic reaction or adverse medication effect; and</li> <li>vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</li> </ul> <p>h. The Family Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and</p> <p>i. Information from the prescribing pharmacy regarding medications must be kept in the</p>			
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<p>home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications.</p> <p>j. Medication Oversight is optional if the individual resides with their biological family (by affinity or consanguinity). If Medication Oversight is not selected as an Ongoing Nursing Service, all elements of medication administration and oversight are the sole responsibility of the individual and their biological family. Therefore, a monthly medication administration record (MAR) is not required unless the family requests it and continually communicates all medication changes to the provider agency in a timely manner to insure accuracy of the MAR.</p> <p>iv. The family must communicate at least annually and as needed for significant change of condition with the agency nurse regarding the current medications and the individual's response to medications for purpose of accurately completing required nursing assessments.</p> <p>v. As per the DDS Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not deliver medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a Certified Medication Aide (CMA). Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements.</p> <p>vi. If the substitute care provider is a surrogate (not related by affinity or consanguinity)</p>			
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<p>Medication Oversight must be selected and provided.</p> <p><b>CHAPTER 12 (SL) 2. Service Requirements L. Training and Requirements: 3. Medication Delivery:</b> Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.</p> <p>l. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;</p> <p>m. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:</p> <p>i. The name of the individual, a transcription of the physician’s or licensed health care provider’s prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;</p> <p>ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>iii. Initials of the individual administering or assisting with the medication delivery;</p> <p>iv. Explanation of any medication error;</p>			
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<p>v. Documentation of any allergic reaction or adverse medication effect; and</p> <p>vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>n. The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and</p> <p>o. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs, and symptoms of adverse events and interactions with other medications.</p> <p><b>CHAPTER 13 (IMLS) 2. Service Requirements. B.</b> There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007  <b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these</p>			
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<p>standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>E. Medication Delivery:</b> Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ul style="list-style-type: none"> <li>(a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;</li> <li>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</li> <li>(c) Initials of the individual administering or assisting with the medication;</li> <li>(d) Explanation of any medication irregularity;</li> <li>(e) Documentation of any allergic reaction or adverse medication effect; and</li> </ul>			
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<p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p>			
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<p>based on the nurse’s assessment of the individual and consideration of the individual’s diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual’s condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual’s response to medication.</p> <p><b>Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006</b></p> <p>C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).</p> <p>a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.</p>			
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<p>4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).  Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013  <b>CHAPTER 5 (CIES) 3. Agency Requirements.</b>  <b>B. Community Integrated Employment</b>  <b>Agency Staffing Requirements:</b> <b>O.</b> Comply with DDSD Medication Assessment and Delivery Policy and Procedures; <b>P.</b> Meet the health, medication and pharmacy needs during the time the individual receives Community Integrated Employment if applicable;</p> <p><b>CHAPTER 6 (CCS) 1. Scope of Service A. Individualized Customized Community Supports 19.</b> Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy; <b>B. Community Inclusion Aide 6.</b> Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy; <b>C. Small Group Customized Community Supports 19.</b> Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy; <b>D. Group Customized Community Supports 19.</b> Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy;</p> <p><b>CHAPTER 11 (FL) 1. Scope of Service. A. Living Supports – Family Living Services 19.</b> Assisting in medication delivery, and related monitoring, in accordance with the DDSD’s Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill</p>			
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<p>development activities leading to the ability for individuals to self-administer medication as appropriate; and...</p> <p>3. Family Living Providers are required to provide Adult Nursing Services and complete the scope of services for nursing assessments and consultation as outlined in the Adult Nursing service standards...</p> <p>a. Adult Nursing Services for medication oversight are required for all surrogate Lining Supports- Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication.</p> <p><b>CHAPTER 12 (SL) 1. Scope of Services A. Living Supports – Supported Living: 20.</b> Assistance in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations, including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and..<b>2. Service Requirements: L. Training and Requirements: 3.</b> Medication Delivery: Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.</p> <p><b>CHAPTER 15 (ANS) 2. Service Requirements. G. For Individuals Receiving Ongoing</b></p>			
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<p><b>Nursing Services for Medication Oversight or Medication Administration:</b></p> <p>1 Nurses will follow the DDSD Medication Administration Assessment Policy and Procedure;</p> <p>3 Nurses will be contacted prior to the delivery of PRN medications by DSP, including surrogate Family Living providers, who are not related by affinity or consanguinity that have successfully completed AWMD or CMA training. Nurses will determine whether to approve the delivery of the PRN medication based on prudent nursing judgment;</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007  <b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.  <b>E. Medication Delivery...</b></p>			
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<p>division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, <a href="http://dhi.health.state.nm.us">http://dhi.health.state.nm.us</a>, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242.</p> <p><b>(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:</b> In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at <a href="http://dhi.health.state.nm.us">http://dhi.health.state.nm.us</a>; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form.</p>			
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<p><b>(3) Limited provider investigation:</b> No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation.</p> <p><b>(4) Immediate action and safety planning:</b> Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall:</p> <ul style="list-style-type: none"> <li><b>(a)</b> develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable;</li> <li><b>(b)</b> be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and</li> <li><b>(c)</b> provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at <a href="http://dhi.health.state.nm.us">http://dhi.health.state.nm.us</a>; otherwise it may be submitted by faxing it to the division at 1-800-584-6057.</li> </ul> <p><b>(5) Evidence preservation:</b> The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident.</p> <p><b>(6) Legal guardian or parental notification:</b> The responsible community-based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and</p>			
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<p>exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative.</p> <p><b>(7) Case manager or consultant notification by community-based service providers:</b> The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant.</p> <p><b>(8) Non-responsible reporter:</b> Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation</p>			
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<p><b>IV. POLICY STATEMENT - Human Rights</b> Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.</p> <p>Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:</p> <ul style="list-style-type: none"> <li>• Aversive Intervention Prohibitions</li> <li>• Psychotropic Medications Use</li> <li>• Behavioral Support Service Provision.</li> </ul> <p>A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.</p> <p><b>A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS</b></p> <p>Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval.</p> <p>2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.</p> <p>3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan.</p>			
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**Department of Health Developmental  
Disabilities Supports Division (DDSD) -  
Procedure Title:**

**Medication Assessment and Delivery  
Procedure Eff Date: November 1, 2006**

**B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).



<p>a. date  b. time administered  c. name of patient  d. dose  e. practitioner's name  f. signature of person administering or assisting with the administration the dose  g. balance of controlled substance remaining.</p>	<ul style="list-style-type: none"> <li>• Neo/poly B/Dex 0.1% ointment is applied to each eye and not kept separate from all other dosage forms.</li> </ul>		
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<p>b. Review implementation and the effectiveness of therapy, healthcare, PBSP, Behavior Crisis Intervention Plan (BCIP), MERP, and Comprehensive Aspiration Risk Management Plan (CARMP) plans if applicable;</p> <p>c. Assist with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator or other IDT members; and</p> <p>d. Monitor the Assistive Technology Inventory to ensure that needed adaptive equipment, augmentative communication and assistive technology devices are available and functioning properly.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES</b></p> <p><b>A. Support to Individuals in Family Living:</b> The Family Living Services Provider Agency shall provide and document:</p> <p>(5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include:</p> <p>(a) Review, advise, and prompt the implementation of the individual's ISP Action Plans, schedule of activities and appointments; and</p> <p>(b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members.</p> <p><b>B. Home Studies.</b> The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support</p>			
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<p>provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS</b></p> <p><b>D. Scope of DDSD Agreement</b></p> <p>(4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite;</p> <p><b>NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER</b></p> <p><b>ELIGIBLE PROVIDERS:</b></p> <p><b>I. Qualifications for community living service providers:</b> There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards.</p> <p>(1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.</p>			
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<p>consistent with the Assisting with Medication Delivery training or each individual's ISP; and</p> <p>q. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.</p> <p><b>CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports-Supported Living Services:</b> 1. Supported Living Provider Agencies must assure that each individual's residence is maintained to be clean, safe, and comfortable and accommodates the individual's daily living, social, and leisure activities. In addition the residence must:</p> <p>f. Maintain basic utilities, i.e., gas, power, water, and telephone;</p> <p>g. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;</p> <p>h. Ensure water temperature in home does not exceed safe temperature (110° F) ;</p> <p>i. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system;</p> <p>j. Have a general-purpose First Aid kit;</p> <p>k. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and</p>	<ul style="list-style-type: none"> <li>• Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 6)</li> </ul>		
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<p>each individual has the right to have his or her own bed;</p> <p>l. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills must occur at least once a year during each shift;</p> <p>m. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and</p> <p>n. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.</p> <p><b>CHAPTER 13 (IMLS) 2. Service Requirements</b>  <b>R. Staff Qualifications: 3. Supervisor Qualifications And Requirements:</b>  S Each residence shall include operable safety equipment, including but not limited to, an operable smoke detector or sprinkler system, a carbon monoxide detector if any natural gas appliance or heating is used, fire extinguisher, general purpose first aid kit, written procedures for emergency evacuation due to fire or other emergency and documentation of evacuation drills occurring at least annually during each shift, phone number for poison control within line of site of the telephone, basic utilities, general household appliances, kitchen and dining utensils, adequate food and drink for three meals per day, proper food storage, and cleaning supplies.</p>			
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<p>T Each residence shall have a blood borne pathogens kit as applicable to the residents' health status, personal protection equipment, and any ordered or required medical supplies shall also be available in the home.</p> <p>U If not medically contraindicated, and with mutual consent, up to two (2) individuals may share a single bedroom. Each individual shall have their own bed. All bedrooms shall have doors that may be closed for privacy. Individuals have the right to decorate their bedroom in a style of their choosing consistent with safe and sanitary living conditions.</p> <p>V For residences with more than two (2) residents, there shall be at least two (2) bathrooms. Toilets, tubs/showers used by the individuals shall provide for privacy and be designed or adapted for the safe provision of personal care. Water temperature shall be maintained at a safe level to prevent injury and ensure comfort and shall not exceed one hundred ten (110) degrees.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007  <b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</b>  <b>L. Residence Requirements for Family Living Services and Supported Living Services</b></p>			
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<p>provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007  <b>CHAPTER 5 XVI. REIMBURSEMENT</b>  <b>A. Billable Unit.</b> A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care.</p> <p><b>B. Billable Activities</b>  (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours.</p> <p>(2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours</p>			
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<p>3. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group.</p> <p>4. The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Customized Community Supports without prior approval from DDS.</p> <p>5. The billable unit for Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit. (There is a separate rate established for individuals who require one-to-one (1:1) support either in the community or in a group day setting due to behavioral challenges (NM DDW group G).</p> <p>6. The billable unit for Fiscal Management for Adult Education is dollars charged for each class including a 10% administrative processing fee.</p> <p><b>C. Billable Activities:</b></p> <p>1. All DSP activities that are:</p> <p>a. Provided face to face with the individual;</p> <p>b. Described in the individual's approved ISP;</p> <p>c. Provided in accordance with the Scope of Services; and</p> <p>d. Activities included in billable services, activities or situations.</p> <p>2. Purchase of tuition, fees, and/or related materials associated with adult education opportunities as related to the ISP Action</p>	<p>Documentation received accounted for 9 units.</p> <p>August 2015</p> <ul style="list-style-type: none"> <li>• The Agency billed 66 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/03/2015 through 8/07/2015. Documentation received accounted for 32 units.</li> <li>• The Agency billed 48 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/10/2015 through 8/14/2015. Documentation received accounted for 8 units.</li> <li>• The Agency billed 66 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/17/2015 through 8/21/2015. Documentation received accounted for 20 units.</li> <li>• The Agency billed 32 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/24/2015 through 8/28/2015. Documentation received accounted for 4 units.</li> </ul> <p>September 2015</p> <ul style="list-style-type: none"> <li>• The Agency billed 29 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/01/2015 through 9/04/2015. Documentation received accounted for 17 units.</li> <li>• The Agency billed 76 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/14/2015 through 9/18/2015. Documentation received accounted for 33 units.</li> </ul>		
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<p>Plan and Outcomes, not to exceed \$550 including administrative processing fee.</p> <p>3. Customized Community Supports can be included in ISP and budget with any other services.</p> <p><b>MAD-MR: 03-59 Eff 1/1/2004</b>  <b>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b>  Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p>	<p>Individual #4</p> <p>July 2015</p> <ul style="list-style-type: none"> <li>• The Agency billed 37 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/01/2015 through 7/03/2015. Documentation received accounted for 18 units.</li> <li>• The Agency billed 53 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/06/2015 through 7/10/2015. Documentation received accounted for 46 units.</li> <li>• The Agency billed 50 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/13/2015 through 7/17/2015. Documentation received accounted for 36 units.</li> <li>• The Agency billed 41 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/20/2015 through 7/24/2015. Documentation received accounted for 27 units.</li> <li>• The Agency billed 45 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/27/2015 through 7/31/2015. Documentation received accounted for 33 units.</li> </ul> <p>August 2015</p> <ul style="list-style-type: none"> <li>• The Agency billed 62 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/03/2015 through 8/07/2015. Documentation received accounted for 54 units.</li> <li>• The Agency billed 50 units of Customized Community Supports (Individual) (H2021 HB</li> </ul>		
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	<p>U1) from 8/17/2015 through 8/21/2015. Documentation received accounted for 40 units.</p> <ul style="list-style-type: none"> <li>• The Agency billed 52 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/24/2015 through 8/28/2015. Documentation received accounted for 48 units.</li> </ul> <p>September 2015</p> <ul style="list-style-type: none"> <li>• The Agency billed 36 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/01/2015 through 9/04/2015. Documentation received accounted for 28 units.</li> <li>• The Agency billed 19 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/08/2015 through 9/11/2015. Documentation received accounted for 15 units.</li> <li>• The Agency billed 63 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/14/2015 through 9/18/2015. Documentation received accounted for 46 units.</li> </ul> <p>Individual #7 July 2015</p> <ul style="list-style-type: none"> <li>• The Agency billed 33 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/01/2015 through 7/03/2015. Documentation received accounted for 16 units.</li> <li>• The Agency billed 86 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/06/2015 through 7/10/2015.</li> </ul>		
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	<p>Documentation received accounted for 82 units.</p> <ul style="list-style-type: none"> <li>• The Agency billed 42 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/13/2015 through 7/17/2015. Documentation received accounted for 40 units.</li> <li>• The Agency billed 47 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/20/2015 through 7/24/2015. Documentation received accounted for 27 units.</li> </ul> <p>August 2015</p> <ul style="list-style-type: none"> <li>• The Agency billed 41 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/03/2015 through 8/7/2015. Documentation received accounted for 34 units.</li> <li>• The Agency billed 59 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/10/2015 through 8/14/2015. Documentation received accounted for 37 units.</li> <li>• The Agency billed 69 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/24/2015 through 8/28/2015. Documentation received accounted for 45 units.</li> <li>• The Agency billed 12 units of Customized Community Supports (Individual) (H2021 HB U1) on 8/31/2015. No documentation was found on 8/31/2015 to justify the 12 units billed.</li> </ul> <p>Individual #8 July 2015</p>		
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	<ul style="list-style-type: none"> <li>• The Agency billed 22 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/06/2015 through 7/10/2015. Documentation received accounted for 17 units.</li> <li>• The Agency billed 12 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/13/2015 through 7/17/2015. Documentation received accounted for 4 units.</li> <li>• The Agency billed 60 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/20/2015 through 7/24/2015. Documentation received accounted for 36 units.</li> <li>• The Agency billed 11 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/27/2015 through 7/31/2015. No documentation was found for 7/27/2015 through 7/31/2015 to justify the 11 units billed.</li> </ul> <p>August 2015</p> <ul style="list-style-type: none"> <li>• The Agency billed 32 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/17/2015 through 8/21/2015. Documentation received accounted for 22 units.</li> </ul> <p>September 2015</p> <ul style="list-style-type: none"> <li>• The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/01/2015 through 9/04/2015. Documentation received accounted for 24 units.</li> <li>• The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB</li> </ul>		
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	<p>U1) from 9/14/2015 through 9/18/2015. Documentation received accounted for 12 units.</p> <p>Individual #9 July 2015</p> <ul style="list-style-type: none"> <li>• The Agency billed 37 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/01/2015 through 7/03/2015. Documentation received accounted for 26 units.</li> <li>• The Agency billed 32 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/13/2015 through 7/17/2015. Documentation received accounted for 28 units.</li> <li>• The Agency billed 43 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/20/2015 through 7/24/2015. Documentation received accounted for 26 units.</li> <li>• The Agency billed 36 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/27/2015 through 7/31/2015. Documentation received accounted for 8 units.</li> </ul> <p>August 2015</p> <ul style="list-style-type: none"> <li>• The Agency billed 44 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/03/2015 through 8/07/2015. Documentation received accounted for 27 units.</li> <li>• The Agency billed 52 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/10/2015 through 8/14/2015.</li> </ul>		
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	<p>Documentation received accounted for 20 units.</p> <ul style="list-style-type: none"> <li>• The Agency billed 49 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/17/2015 through 8/21/2015. Documentation received accounted for 14 units.</li> </ul> <p>September 2015</p> <ul style="list-style-type: none"> <li>• The Agency billed 56 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/08/2015 through 9/11/2015. Documentation received accounted for 29 units.</li> <li>• The Agency billed 63 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/14/2015 through 9/18/2015. Documentation received accounted for 52 units.</li> </ul>		
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Tag # LS26 / 6L26 Supported Living Reimbursement	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</p> <p><b>CHAPTER 12 (SL) 2. REIMBURSEMENT</b></p> <p><b>A. Supported Living Provider Agencies</b> must maintain all records necessary to fully disclose the type, quality, quantity, and clinical necessity of services furnished to individuals who are currently receiving services. The Supported Living Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed.</p> <p>3. The documentation of the billable time spent with an individual must be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit billed, the record must contain the following:</p> <ol style="list-style-type: none"> <li>Date, start and end time of each service encounter or other billable service interval;</li> <li>A description of what occurred during the encounter or service interval;</li> <li>The signature or authenticated name of staff providing the service;</li> <li>The rate for Supported Living is based on categories associated with each individual's NM DDW Group; and</li> <li>A non-ambulatory stipend is available for those who meet assessed need requirement.</li> </ol> <p><b>B. Billable Units:</b></p> <ol style="list-style-type: none"> <li>The billable unit for Supported Living is based on a daily rate. A day is determined based on whether the individual was residing in the home at midnight.</li> </ol>	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 1 of 7 individuals.</p> <p>Individual #8 July 2015</p> <ul style="list-style-type: none"> <li>The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/02/2015. No documentation was found on 7/02/2015 to justify the 1 unit billed.</li> <li>The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/27/2015. No documentation was found on 7/27/2015 to justify the 1 unit billed.</li> </ul> <p>August 2015</p> <ul style="list-style-type: none"> <li>The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/05/2015. No documentation was found on 8/05/2015 to justify the 1 unit billed.</li> <li>The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/19/2015. No documentation was found on 8/19/2015 to justify the 1 unit billed.</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>2. The maximum allowable billable units cannot exceed three hundred forty (340) calendar days per ISP year or one hundred seventy (170) calendar days per six (6) months.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p><b>B. Billable Units:</b> The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ol style="list-style-type: none"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ol> <p><b>MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b></p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p>			
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<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</b></p> <p>A. <b>Reimbursement</b> for Supported Living Services</p> <p>(1) <b>Billable Unit.</b> The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year.</p> <p>(2) <b>Billable Activities</b></p> <p>(a) Direct care provided to an individual in the residence any portion of the day.</p> <p>(b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community.</p> <p>(c) Any activities in which direct support staff provides in accordance with the Scope of Services.</p> <p>(3) <b>Non-Billable Activities</b></p> <p>(a) The Supported Living Services provider shall not bill DD Waiver for Room and Board.</p> <p>(b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services.</p> <p>(c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.</p>			
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Date: April 21, 2016

To: Hector Johnson, Associate Executive Director  
Provider: Community Options, Inc.  
Address: 2500 Missouri Ave.  
State/Zip: Las Cruces, New Mexico 88011

E-mail Address: [hector.johnson@comop.org](mailto:hector.johnson@comop.org)

CC: Robert Stack, Chief Executive Officer  
Address: 16 Farber Road  
State/Zip: Princeton, New Jersey 08540

E-Mail Address [robert.stack@comop.org](mailto:robert.stack@comop.org)

Region: Northeast  
Survey Date: October 19 – 22, 2015  
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012: Living Supports** (Supported Living, Family Living); **Inclusion Supports** (Customized Community Supports)  
**2007: Community Living** (Supported Living) and **Community Inclusion** (Adult Habilitation)

Survey Type: Routine

Dear Mr. Johnson:

The Division of Health Improvement Quality Management Bureau received and reviewed the documents you submitted for your Plan of Correction. Your Plan of Correction is not closed.

**Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.**

The Quality Management Bureau will be need to conduct a verification survey to ensure previously cited deficiencies have been corrected and that systemic Quality Improvement and Quality Assurance processes have been effective at sustaining corrections.

After reviewing the documentation submitted through your Plan of Correction, the following items are still outstanding:

Tag 1A08.2

- Decision Consultation Forms for the following: *(Please note, documentation provided indicated both individuals were refusing all appointments.)*
  - Individual #1
    - Vision Exam
  - Individual #9
    - Dental Exam
    - Vision Exam

- Cholesterol and Blood Glucose
- Blood Levels

Tag 1A09

- Individual #3
  - Polyethylene Glycol 17gm/1 dose powder same dosage
    - Physician Order states “4-8oz 1 time daily, every other day”. Medication Administration Record (MAR) provided during the POC process stated “drink daily 4 times a week”. However, the MAR was initialed daily, indicating medication was being provided every day.

Tag LS25/6L25

- Evidence water temperature in homes do not exceed 110°F (#3, 4, 8, 9). *(Please note, “Weekly Water Temperature Check” Log provided during POC process does not specify which homes were checked.)*
- Evidence fire extinguishers have been placed in homes (#3, 4, 8, 9). *(Please note, only receipt of purchase for extinguishers was provided during POC process.)*

If the Verification survey determines survey deficiencies have been corrected and corrective measures have effectively maintained compliance with DDW Standards, your Plan of Correction will be considered for closure.

If the Verification survey identifies repeat deficiencies, the Plan of Correction process will continue and your case may be referred to the Internal Review Committee for discussion of possible civil monetary penalties possible monetary fines and/or other sanctions.

Thank you for your cooperation with the Plan of Correction process.

Sincerely,

*Amanda Castañeda*

Amanda Castañeda  
Health Program Manager/Plan of Correction Coordinator  
Quality Management Bureau/DHI

Q.16.2.DDW.D3124.2.RTN.07.16.112