

SUSANA MARTINEZ, GOVERNOR

CATHERINE D. TORRES, M.D., CABINET SECRETARY

Date: September 14, 2012

To: Johnny Sanchez, Director of Operations/Service Coordinator

Provider: Mis Amigos Family Services, LLC

Address: 109 East Main Street State/Zip: Tucumcari, NM 88401

E-mail Address: jsanchez@misamigosfamilyservices.com

CC: Sheryl Aspelin, Executive Director/Board Chair

Board Chair <u>saspelin@misamigosfamilyservices.com</u>

Region: Southeast

Survey Date: July 30 – August 1, 2012

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Community Living Supports (Supported Living, Family Living & Independent Living) &

Community Inclusion Supports (Adult Habilitation, Community Access & Supported

Employment)

Survey Type: Initial

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

Bureau

Team Members: Mari Chavez, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management

Bureau

Dear Mr. Sanchez:

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:

Compliance with all Conditions of Participation.

This determination is based on your agency's compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.



DIVISION OF HEALTH IMPROVEMENT • QUALITY MANAGEMENT BUREAU

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

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:

- Quality Management Bureau, Attention: Plan of Correction Coordinator 5301 Central Ave. NE Suite 400 Albuquerque, NM 87108
- 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.

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 at 505-699-9356 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,

Deb Russell, BS

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

Survey Process Employed:

July 30, 2012 Entrance Conference Date: Present: Mis Amigos Family Services, LLC Sheryl Aspelin, Executive Director Johnny Sanchez, Service Coordinator DOH/DHI/QMB Deb Russell, BS, Team Lead/Healthcare Surveyor Mari Chavez, BSW, Healthcare Surveyor Exit Conference Date: August 1, 2012 Present: Mis Amigos Family Services, LLC Sheryl Aspelin, Executive Director Johnny Sanchez, Service Coordinator DOH/DHI/QMB Deb Russell, BS, Team Lead/Healthcare Surveyor Mari Chavez, BSW, Healthcare Surveyor **DDSD - Southeast Regional Office** Brianna Massey, by telephone conference Total Homes Visited Number: Supported Homes Visited Number: Family Homes Visited Number: 2 Administrative Locations Visited Number: 1 **Total Sample Size** Number: 0 - Jackson Class Members 5 - Non-Jackson Class Members 2 - Supported Living 2 - Family Living 1 - Independent Living 5 - Adult Habilitation 3 - Community Access 2 - Supported Employment Persons Served Records Reviewed Number: 5 Persons Served Interviewed Number: 5 Direct Support Personnel Interviewed Number: 6

Direct Support Personnel Records Reviewed Number: 17

Service Coordinator Records Reviewed Number: 2

Administrative Files Reviewed

Billing Records

Medical Records

- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Evacuation Drills
- 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

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 non compliance.

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

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-699-9356 or email at Crystal.Lopez-Beck@state.nm.us. Requests for technical assistance must be requested through your DDSD Regional 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 required six CMS core elements to address each deficiency of the POC:

- 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 POC:

- 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, Incident Reporting, and Individual-Specific service requirements, etc;
- How accuracy in Billing documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how ISPs 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; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

Note: <u>Instruction or in-service of staff alone may not be a sufficient plan of correction.</u> This is a good first step toward correction, but additional steps should 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 QMB POC Coordinator, Crystal Lopez-Beck at 505-699-9356 for assistance.
- 3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- 4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:
 - a. Electronically at Crystal.Lopez-Beck@state.nm.us (preferred method)
 - b. Fax to 505-222-8661, or
 - c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
- 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 "approve" 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.
- 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 <u>maximum</u> of 45 business days of receipt of your Report of Findings.
- 2. You may submit your documents by postal mail (paper hard copy or on a disc), fax, or electronically (scanned and attached to e-mails).
- 3. All submitted documents <u>must be annotated</u>; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
- 4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
- 5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
- 6. For billing deficiencies, you must submit:
 - a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
 - b. Copies of "void and adjust" forms submitted to correct all over-billed or unjustified units billed identified 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 Deputy Chief at QMB, 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.

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) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. 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.

• "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 one (1) to three (3) 'Conditions of Participation.' 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).

Providers receiving a <u>repeat</u> determination of 'Partial-Compliance' for repeat deficiencies of CoPs may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

• "Non-Compliant 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 and/or has:

- Four (4) Conditions of Participation out of compliance.
- Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
- Any finding of actual harm or Immediate Jeopardy.

The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

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

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 in writing to the QMB Deputy Bureau Chief <u>within 10 business days</u> 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 IRC process, email the IRF Chairperson, Scott Good at scott.good@state.nm.us for assistance.

The following limitations apply to the IRF process:

- The 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 made 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: Mis Amigo Family Services, LLC - Southeast Region

Program: Developmental Disabilities Waiver

Service: Community Living Supports (Supported Living, Family Living & Independent Living) & Community Inclusion

Supports (Adult Habilitation, Community Access& Supported Employment)

Monitoring Type: Initial Survey

Date of Survey: July 30, 2012 – August 1, 2012

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due	
CMS Assurance - Service Plans: ISP II	mplementation – Services are delivered ir	n accordance with the service plan, includin	g type,	
scope, amount, duration and frequency specified in the service plan.				
Tag # 1A08 Agency Case File	Standard Level Deficiency			
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: 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. 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	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 1 of 5 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current: • ISP Teaching & Support Strategies • Individual #3 - TASS not found for the following Action Steps: > Take 4 out of town trips – "Plan and go on 4 out of town trips."	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →		

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		
whenever an individual changes provider		
agencies: (a) Complete file for the past 12 months;		
(b) ISP and quarterly reports from the current		
and prior ISP year;		
(c) Intake information from original admission		
to services; and		
to services, and		

(d) When applicable, the Individual

Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.

NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: 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.		
B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.		

Tag # 1A32 & 6L14 ISP Implementation	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.	Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 5 of 5 individuals. Per Individuals ISP the following was found with	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with	regards to the implementation of ISP Outcomes: Administrative Files Reviewed: Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes: Individual #1 None found for 1/2012	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage	Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes: Individual #4 • None found regarding: Plan & cook meal: ° "Cook & serve meal," for 6/2012 ° "Learn to use knife," for 1/2012 – 3/2012 & 6/2012		
independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain	Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes: Individual #3 None found regarding: "Make special occasion cards," for 3/2012 & 5/2012		
opportunities for individuals to live, work and	Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP		

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]

Outcomes:

Individual #3

• None found for 1/2012 - 6/2012

Individual #4

 None found regarding: "Learn new skill," for 11/2011 – 6/2012

Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #3

None found for 4/2012 - 6/2012

Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #5

 None found regarding: "Volunteer position," for 4/2012 – 5/2012

Residential Files Reviewed:

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

Individual #2

None found for 7/1/2012 – 7/30/2012

Tag # 5l11 Reporting Requirements (Community Inclusion Quarterly Reports)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS	Based on record review, the Agency failed to complete quarterly reports as required for 1 of 5 individuals receiving Community Inclusion services.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
E. Provider Agency Reporting Requirements: 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: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age- appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (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.	Supported Employment Quarterly Reports Individual #3 - None found for 11/2011 – 2/2012	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Tag # 6L14 Residential Case File	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 2 of 4 Individuals receiving Family Living Services and Supported Living Services.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
A. Residence Case File: 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: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (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 dentist name, address and telephone number, and health plan; (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); (5) Data collected to document ISP Action Plan implementation	The following was not found, incomplete and/or not current: • Positive Behavioral Plan (#5) • Health Care Plans • Constipation (#1) • Oral Hygiene (#5) • Crisis Plan/Medical Emergency Response Plans • Aspiration (#5) • Progress Notes/Daily Contacts Logs: • Individual #5 - None found for 7/16/2012 – 7/30/2012	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

(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; (7) Physician's or qualified health care providers written orders: (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery: (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (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.		
(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		
(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.		

Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS	Based on record review, the Agency failed to complete written quarterly status reports for 1 of 5 individuals receiving Community Living Services.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
 D. Community Living Service Provider Agency Reporting Requirements: 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: (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members. 	Family Living Quarterly Reports: • Individual #5 - None found for 4/2012 - 6/2012	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
		rtified providers to assure adherence to wai rovider training is conducted in accordance	
Tag # 1A11.1 Transportation Training	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: 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 Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date: March 1, 2007	Based on record review, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 2 of 17 Direct Support Personnel. No documented evidence was found of the following required training: • Transportation (DSP #43 & 56)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
II. POLICY STATEMENTS: I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines			

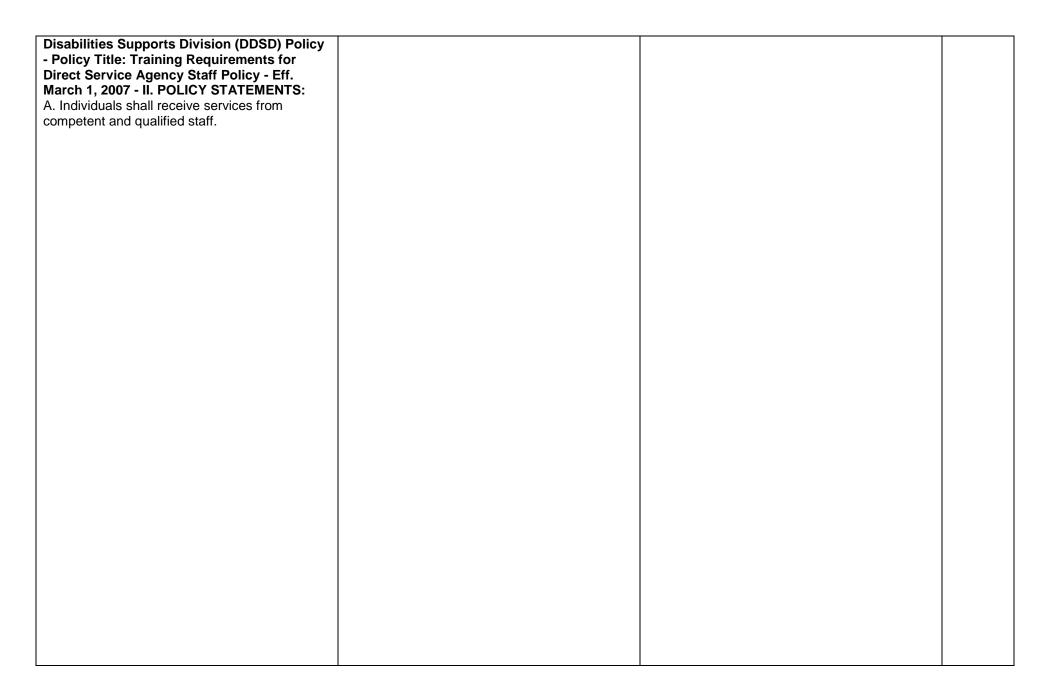
for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)		

Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 17 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Person-Centered Planning (1-Day) (DSP #53)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for			

Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on DOHapproved incident reporting procedures in accordance with 7 NMAC 1.13. D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/quidelines. F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001. I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.

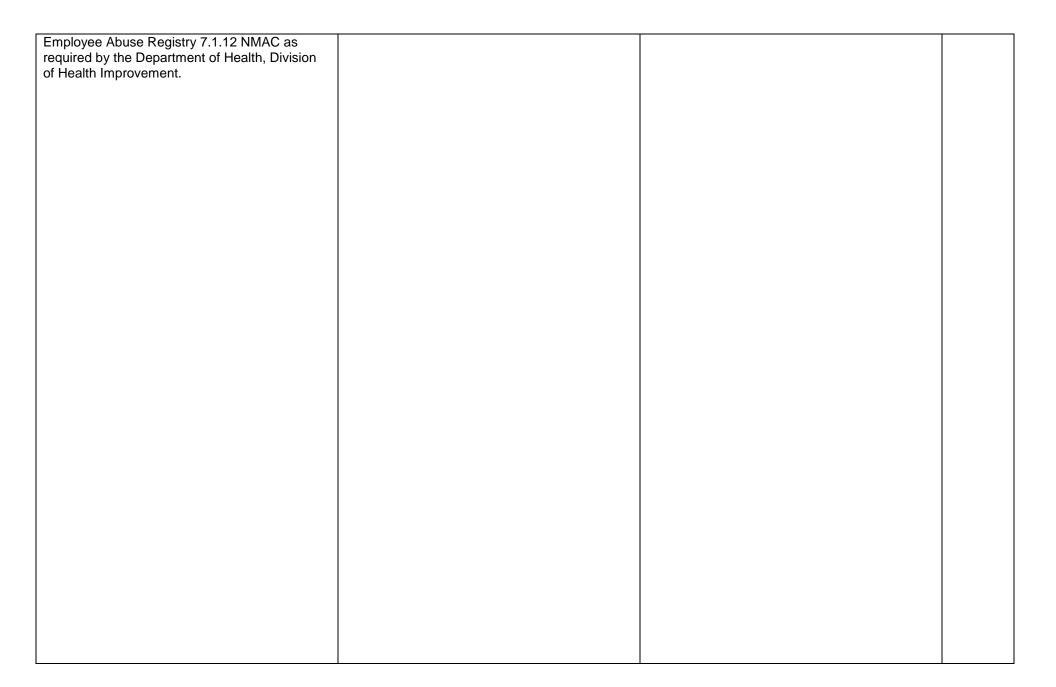
Tag # 1A22 Agency Personnel	Standard Level Deficiency		
Competency	• • • • • • • • • • • • • • • • • • •		
Developmental Disabilities (DD) Waiver Service	Based on interview, the Agency failed to ensure	Provider:	
Standards effective 4/1/2007	that training competencies were met for 2 of 6	State your Plan of Correction for the	. ,
CHAPTER 1 IV. GENERAL REQUIREMENTS	Direct Support Personnel.	deficiencies cited in this tag here: →	
FOR PROVIDER AGENCY SERVICE			
PERSONNEL: The objective of this section is to	When DSP were asked if the Individual had		
establish personnel standards for DD Medicaid	Health Care Plans and if so, what the plan(s)		
Waiver Provider Agencies for the following	covered, the following was reported:		
services: Community Living Supports,			
Community Inclusion Services, Respite,	 DSP #43 stated, "No." As indicated by the 		
Substitute Care and Personal Support	Agency file, the Individual has Health Care		
Companion Services. These standards apply to	Plans for Risk of Heart Disease Due to		
all personnel who provide services, whether	Increased BMI & Oral Hygiene. (Individual		
directly employed or subcontracting with the	#4)		
Provider Agency. Additional personnel		Provider:	
requirements and qualifications may be	When DSP were asked if the Individual had a	Enter your ongoing Quality Assurance/Quality	
applicable for specific service standards.	Medical Emergency Response Plans and if	Improvement processes as it related to this tag	
F. Qualifications for Direct Service	so, what the plan(s) covered, the following	number here: →	
Personnel: The following employment	was reported:		
qualifications and competency requirements are			
applicable to all Direct Service Personnel	 DSP #55 stated, "No." As indicated by the 		
employed by a Provider Agency:	Electronic Comprehensive Health		
(1) Direct service personnel shall be eighteen	Assessment Tool, the Individual requires		
(18) years or older. Exception: Adult	Medical Emergency Response Plans for		
Habilitation can employ direct care personnel	Respiratory. (Individual #2)		
under the age of eighteen 18 years, but the			
employee shall work directly under a	When DSP were asked, what steps are you to		
supervisor, who is physically present at all	take in the event of a medication error, the		
times;	following was reported:		
(2) Direct service personnel shall have the ability	DSP #55 stated, "Throw it away and mark it		
to read and carry out the requirements in an	on the destruction sheet." (Individual #2)		
ISP;	Per The Agency Medication Destruction		
IOF,	Policy, "Single doses will be removed and		
(3) Direct service personnel shall be available to	placed in a small bag and the medication		
communicate in the language that is	destruction form will be filled out and		
functionally required by the individual or in the	attached. Medications will be returned to the		
use of any specific augmentative	supplying pharmacy."		
communication system utilized by the			
Communication system utilized by the			

individual;			
(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and			
(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.			
 (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and 			
(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, interprovider Agency position changes, and name changes. Department of Health (DOH) Developmental			
Department of Health (DOH) Developmental	T and the second	T and the second	1

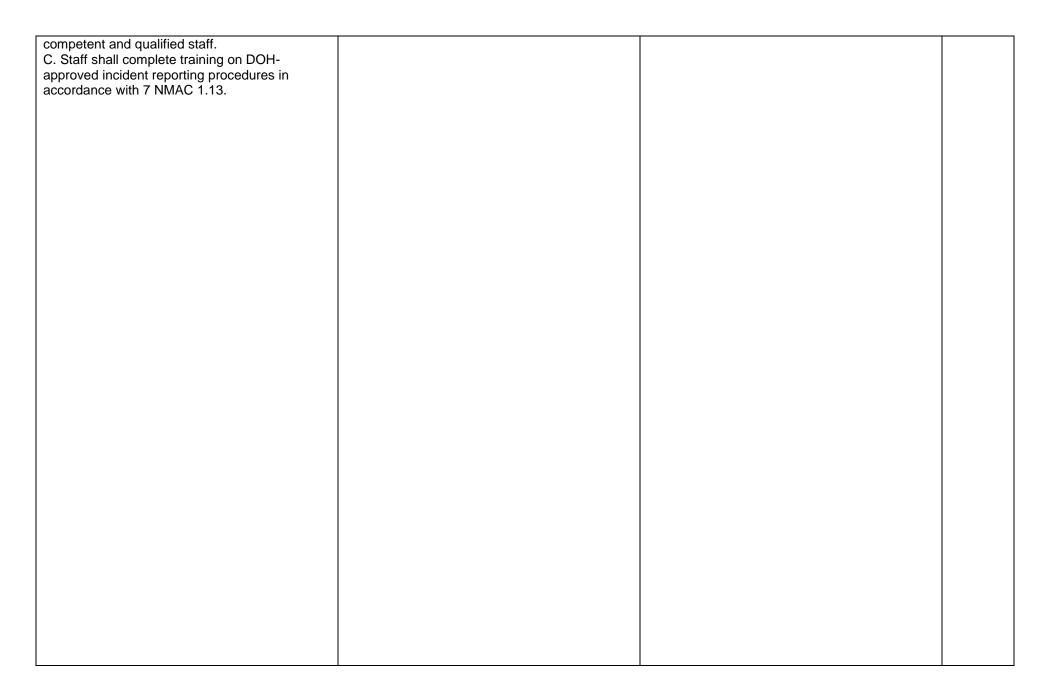


Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	Standard Level Deficiency		
NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 1 of 19 Agency Personnel. The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire: Direct Support Personnel (DSP): #53 – Date of hire 3/21/2012, completed 4/13/2012.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

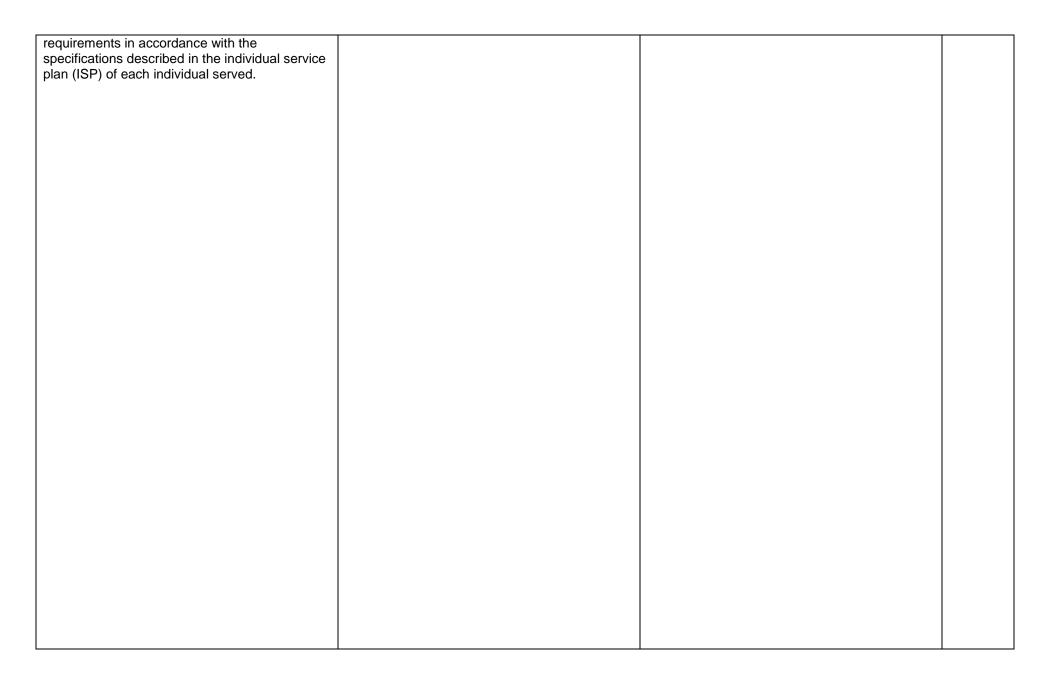
documentation must include evidence, based on		
the response to such inquiry received from the		
custodian by the provider, that the employee		
was not listed on the registry as having a		
substantiated registry-referred incident of abuse,		
neglect or exploitation.		
E. Documentation for other staff . With		
respect to all employed or contracted individuals		
providing direct care who are licensed health		
care professionals or certified nurse aides, the		
provider shall maintain documentation reflecting		
the individual's current licensure as a health		
care professional or current certification as a		
nurse aide.		
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.		
Developmental Disabilities (DD) Waiver Service		
Standards effective 4/1/2007		
Chapter 1.IV. General Provider		
Requirements. D. Criminal History		
Screening: All personnel shall be screened by		
the Provider Agency in regard to the employee's		
qualifications, references, and employment		
history, prior to employment. All Provider		
Agencies shall comply with the Criminal Records		
Screening for Caregivers 7.1.12 NMAC and		



Tag # 1A28.1 Incident Mgt. System -	Standard Level Deficiency		
Personnel Training	Otalidal a Level Delibiology		
NMAC 7.1.13.10 INCIDENT MANAGEMENT	Based on interview, the Agency failed to provide	Provider:	
SYSTEM REQUIREMENTS:	Incident Management Training for 1 of 19	State your Plan of Correction for the	
A. General: All licensed health care facilities	Agency Personnel.	deficiencies cited in this tag here: →	
and community based service providers shall	Agency i cradinici.	deficiencies cited in this tag here.	
establish and maintain an incident management	When Direct Support Personnel were asked		
system, which emphasizes the principles of	what two State Agencies must be contacted		
prevention and staff involvement. The licensed	when there is suspected Abuse, Neglect &		
health care facility or community based service	Misappropriation of Consumers' Property,		
provider shall ensure that the incident	the following was reported:		
management system policies and procedures	the following was reported:		
requires all employees to be competently trained	DSP #43 stated, "The Agency." Staff was not.		
to respond to, report, and document incidents in	able to identify the two State Agencies as		
a timely and accurate manner.	APS & DHI.		
D. Training Documentation: All licensed	APS & DITI.	Provider:	
health care facilities and community based		Enter your ongoing Quality Assurance/Quality	
service providers shall prepare training		Improvement processes as it related to this tag	
documentation for each employee to include a		number here: →	
signed statement indicating the date, time, and		number nere. →	
place they received their incident management			
reporting instruction. The licensed health care			
facility and community based service provider			
shall maintain documentation of an employee's			
training for a period of at least twelve (12)			
months, or six (6) months after termination of an			
employee's employment. Training curricula shall			
be kept on the provider premises and made			
available on request by the department. Training			
documentation shall be made available			
immediately upon a division representative's			
request. Failure to provide employee training			
documentation shall subject the licensed health			
care facility or community based service			
provider to the penalties provided for in this rule.			
Policy Title: Training Requirements for Direct			
Service Agency Staff Policy - Eff. March 1,			
2007			
II. POLICY STATEMENTS:			
A. Individuals shall receive services from			



Tag # 1A37 Individual Specific Training	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as "Addendum B") training	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 1 of 19 Agency Personnel. Review of personnel records found no evidence of the following: Direct Support Personnel (DSP): Individual Specific Training (#47)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	



Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
	als shall be afforded their basic human righ	, addresses and seeks to prevent occurrents. The provider supports individuals to ac	
- Routine Medication	Standard Level Deniclency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: 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	Medication Administration Records (MAR) were reviewed for the months of May, June & July 2012. Based on record review, 1 of 4 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. 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.	Individual #2 July 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Diamox 250mg (1 time daily) • Fish Oil 1000mg (2 times daily) • Oystcal 500mg (2 times daily)	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
 (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, diagnosis for which the medication is prescribed: (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (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. (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: (4) MARs are not required for individuals participating in Independent Living who selfadminister their own medications; (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 administrating the medication, signs and symptoms of adverse events and interactions with other medications; NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND **RECORD KEEPING OF DRUGS:**

(d) The facility shall have a Medication

Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include: Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: > symptoms that indicate the use of the medication, > exact dosage to be used, and the exact amount to be used in a 24 hour period.

Tag # 1A09.1 Medication Delivery - PRN Medication	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: 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. 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,	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 1 of 4 Individuals. Individual #2 June 2012 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • ProAir HFA 90mcg – PRN – 6/10 (given 2 times) (8:00 AM)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and			
method/route of administration, times and dates of administration;			

(c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (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. (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; (4) MARs are not required for individuals participating in Independent Living who selfadminister their own medications: (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 administrating the medication, signs and symptoms of adverse events and interactions with other medications: NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE **DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication

Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications.

This documentation shall include:

- (i) Name of resident;
 (ii) Date given;
 (iii) Drug product name;
 (iv) Dosage and form;
 (v) Strength of drug;
 (vi) Route of administration;
 (vii) How often medication is to be taken;
 (viii) Time taken and staff initials;
 (iv) Dates when the medication is
 - (ix) Dates when the medication is discontinued or changed;
 - (x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual D. Administration of Drugs

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications.

Document the practitioner's order authorizing the self-administration of medications.

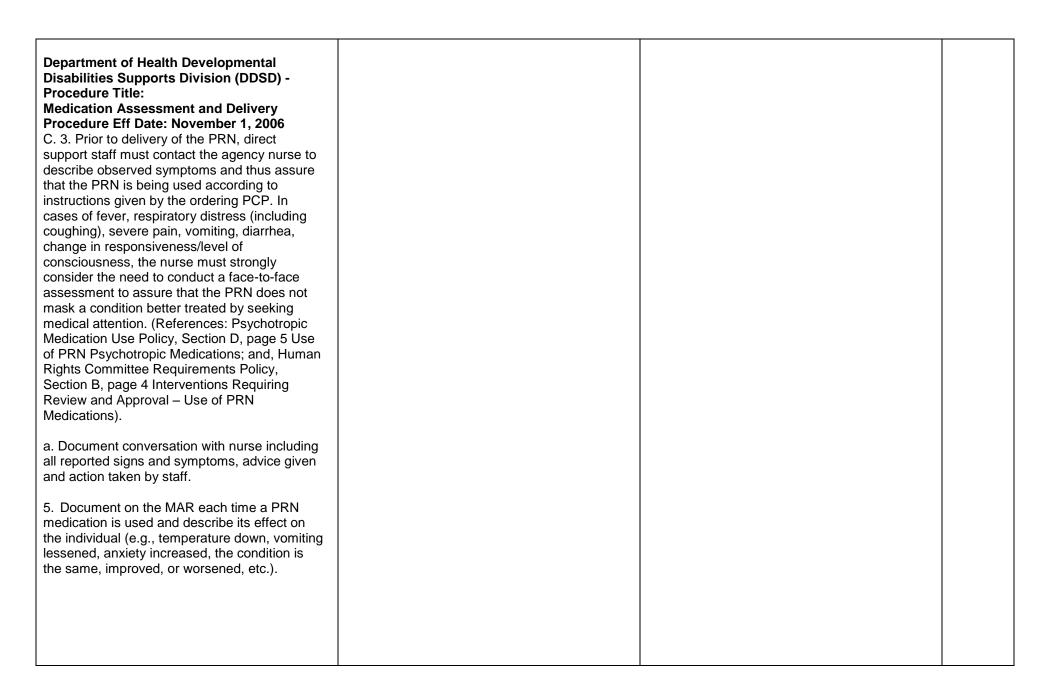
All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- > symptoms that indicate the use of the medication,
- > exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006 F. PRN Medication

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.		
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).		
H. Agency Nurse Monitoring		
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.		
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.		



T # 4404 OF (D' 14 #1 D' 14	00		
Tag # 1A31 Client Rights/Human Rights	Standard Level Deficiency		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] Long Term Services Division Policy Title: Human Rights Committee	Based on record review, the Agency failed to follow DDSD Policy regarding Human Rights Committee Requirements. Review of the Agency Policy & Procedure found the policy did not address the frequency of meetings and did not address Behavior Support Plans approved by the Human Rights Committee are to be reviewed at least quarterly.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

IV. POLICY STATEMENT - Human Rights 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.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:

- Aversive Intervention Prohibitions
- Psychotropic Medications Use
- Behavioral Support Service Provision.

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.

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS

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.

- 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.
- 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.

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).		

Tag # 6L06 Family Living Requirements	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver	Based on record review, the Agency failed to	Provider:	
Service Standards effective 4/1/2007	complete all DDSD requirements for approval of	State your Plan of Correction for the	
	each direct support provider for 1 of 2	deficiencies cited in this tag here: →	
CHAPTER 6. III. REQUIREMENTS UNIQUE	individuals.		
TO FAMILY LIVING SERVICES			
A. Support to Individuals in Family Living:	The following was not found, not current and/or		
The Family Living Services Provider Agency	incomplete:		
shall provide and document:			
(-)	Monthly Consultation with the Direct		
(5) Monthly consultation, by agency	Support Provider		
supervisors or internal service	° Individual #4 - None found for 1/2012 &		
coordinators, with the direct support	2/2012.		
provider to include:		Provider:	
(a) Review, advise, and prompt the		Enter your ongoing Quality Assurance/Quality	
implementation of the individual's ISP		Improvement processes as it related to this tag	
Action Plans, schedule of activities		number here: →	
and appointments; and		Training Horo.	
and appointments, and			
(b) Assist with service or support issues			
raised by the direct support provider			
or observed by supervisor, service			
coordinator or other IDT members.			
B. Home Studies. The Family Living Services			
Provider Agency shall complete all DDSD			
requirements for approval of each direct			
support 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.			
, as app. 3.34 a) 22 32.			
Developmental Disabilities (DD) Waiver			
Service Standards effective 4/1/2007			

CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS D. Scope of DDSD Agreement (4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite; NMAC 8.314.5.10 - DEVELOPMENTAL **DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER ELIGIBLE PROVIDERS:** I. Qualifications for community living service providers: 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. (1) Family living service providers for adults must meet the qualifications for staff required bv 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.

Tag # 6L13 Community Living Healthcare Regts.	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING G. Health Care Requirements for Community Living Services. (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 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, which ever comes first. (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 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. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as	Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 2 of 5 individuals receiving Community Living Services. The following was not found, incomplete and/or not current: • Dental Exam • Individual #3 - As indicated by collateral documentation reviewed, exam was completed on 11/1/2010. Follow-up was to be completed in 12 months. No evidence of follow-up found. • Vision Exam • Individual #5 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

detailed in Chapter One section III E:	
Healthcare Documentation by Nurses For	
Community Living Services, Community	
Inclusion Services and Private Duty	
Nursing Services.	
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.	
(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.	
(4) That an average of 3 hours of documented	
nutritional counseling is available annually, if	
recommended by the IDT.	
(5) That the physical property and grounds are	
free of hazards to the individual's health and	
safety.	
(6) In addition, for each individual receiving	
Supported Living or Family Living Services, the	
provider shall verify and document the	
following:	
(a)The individual has a primary licensed	
physician; (b)The individual receives an annual	
physical examination and other	
examinations as specified by a licensed	
physician;	
(c)The individual receives annual dental	
check-ups and other check-ups as	
specified by a licensed dentist;	
(d)The individual receives eye examinations	
as specified by a licensed optometrist or	
ophthalmologist; and	
(e) Agency activities that occur as follow-up	
to medical appointments (e.g. treatment,	
visits to specialists, changes in	
medication or daily routine).	

<u> </u>	-	

Tag # 6L25 Residential Health & Safety (Supported Living & Family Living)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007	Based on observation, the Agency failed to ensure that each individual's residence met all	Provider: State your Plan of Correction for the	
CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY		deficiencies cited in this tag here: →	
REQUIREMENTS L. Residence Requirements for Family	The following items were not found, not		
Living Services and Supported Living Services	functioning or incomplete:		
(1) Supported Living Services and Family Living Services providers shall assure that	Supported Living Requirements:		
each individual's residence has: (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;	 Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1) 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 	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
(f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once	and/or hazardous waste spills, and flooding (#1) Family Living Requirements:		
a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each	 Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#4 & 5) Accessible written procedures for the safe 		
individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence	storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#4)		

unsuitable for occupancy. The emergency evacuation procedures shall address, but	Accessible written procedures for emergency	
are not limited to, fire, chemical and/or	placement and relocation of individuals in the	
hazardous waste spills, and flooding.	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 (#4 & 5)	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
	mbursement/Financial Accountability – n the reimbursement methodology specifie	State financial oversight exists to assure the d in the approved waiver.	at claims
Tag # 5l36 Community Access Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION A. General: 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. B. Billable Units: 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: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 2 of 3 individuals. Individual #2 June 2012 • The Agency billed 12 units of Community Access (H2021 U1) on 6/21/2012. Documentation received accounted for 0 units. Individual #3 April 2012 • The Agency billed 46 units of Community Access (H2021 U1) on 4/19/2012. Documentation received accounted for 0 units.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:			

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.		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS G. Reimbursement (1) Billable Unit: A billable unit is defined as one-quarter hour of service.		
(2) Billable Activities: The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed 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 is tied directly to the individual's ISP, Action Plan; (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and (c) Non face-to-face hours do not exceed 10% of the monthly billable hours. 		
(3) Non-Billable Activities: Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include: (a) Time and expense for training service		

(a) Time and expense for training service

personnel; (b) Supervision of agency staff; (c) Service documentation and billing		
(1) 0		
(b) Supervision of agency staff;		
(c) Service documentation and hilling		
(c) Service documentation and billing		
activities; or (d) Time the individual spends in segregated facility-based settings activities.		
(al) Time a the align dividual amount of in a common at a d		
(a) Time the individual spends in segregated		
facility-hased settings activities		
racinty based settings activities.		

recoupment.		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 5 XVI. REIMBURSEMENT A. Billable Unit. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care.		
B. Billable Activities (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.		
(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		

SUSANA MARTINEZ, GOVERNOR



BRAD McGRATH, INTERIM SECRETARY

Date: November 20, 2012

To: Johnny Sanchez, Director of Operations/Service Coordinator

Provider: Mis Amigos Family Services, LLC

Address: 109 East Main Street State/Zip: Tucumcari, NM 88401

E-mail Address: isanchez@misamigosfamilyservices.com

CC: Sheryl Aspelin, Executive Director/Board Chair

Board Chair <u>saspelin@misamigosfamilyservices.com</u>

Region: Southeast

Survey Date: July 30 – August 1, 2012

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Community Living Supports (Supported Living, Family Living & Independent

Living) & Community Inclusion Supports (Adult Habilitation, Community

Access & Supported Employment)

Survey Type: Initial

Dear Mr. Sanchez:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.13.2.DDW.08622868.4.001.INT.09.325

