

Date: December 08, 2014

To: Christina Martinez, Executive Director  
Provider: The Opportunity Center, Inc.  
Address: 905 Tenth Street  
State/Zip: Alamogordo, New Mexico 88310

E-mail Address: [christina\\_oppcenter@hotmail.com](mailto:christina_oppcenter@hotmail.com)

CC: Philip Gutierrez, President of the Board  
Address: 1300 N. White Sands  
State/Zip: Alamogordo, New Mexico 88310

Vice President: Dr. Norman Lindley  
E-Mail Address: [elmedico23@hotmail.com](mailto:elmedico23@hotmail.com)

Region: Southwest  
Survey Date: October 6 - 8, 2014  
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012: Living Supports** (Supported Living); **Inclusion Supports** (Customized Community Supports, Community Integrated Employment Services) and **Other** (Customized In-Home Supports)

Survey Type: Routine  
Team Leader: Florence G. Mulheron, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Amanda E. Castaneda, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Martinez;

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>

QMB Report of Findings – The Opportunity Center, Inc. – Southwest Region – October 6 – 8, 2014

Survey Report #: Q.15.2.DDW.D1556.3.RTN.01.14.342

This determination is based on non-compliance 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.

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

- Tag #1A32 and LS14 / 6L14 Individual Service Plan Implementation
- Tag # 1A22 Agency Personnel Competency

**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: 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 Anthony Fragua at 505-231-7436 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,

*Florence G. Mulheron, BA*

Florence G. Mulheron, BA  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: October 6, 2014

Present: **The Opportunity Center, Inc.**  
Christina Martinez, Director

**DOH/DHI/QMB**

Florence G. Mulheron, BA, Team Lead/Healthcare Surveyor  
Amanda E. Castaneda, MPA, Healthcare Surveyor

Exit Conference Date: October 8, 2014

Present: **The Opportunity Center, Inc.**  
Christina Martinez, Director

Teresa Anschutz, Service Coordinator

Doug Moots, Director of Nursing

Mindy Ostic, Health Services Administrative Assistant

Apryl Stickels, Finance Coordinator

Clarence Wallace, Incident Coordinator/QE Coordinator

**DOH/DHI/QMB**

Florence G. Mulheron, BA, Team Lead/Healthcare Surveyor  
Amanda E. Castaneda, MPA, Healthcare Surveyor

**DDSD - Southwest Regional Office**

Jeana Caruthers, Southwest Regional Director

Administrative Locations Visited Number: 1

Total Sample Size Number: 6

0 - Jackson Class Members

6 - Non-Jackson Class Members

5 - Supported Living

5 - Customized Community Supports

1 - Community Integrated Employment Services

1 - Customized In-Home Supports

Total Homes Visited Number: 3

❖ Supported Living Homes Visited Number: 3

*Note: The following Individuals share a SL residence:*

➤ #3, 4, 5

Persons Served Records Reviewed Number: 6

Persons Served Interviewed Number: 6

Direct Support Personnel Interviewed Number: 7

Direct Support Personnel Records Reviewed Number: 37

## 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
- Representative Payee

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 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 505-231-7436 or email at [Anthony.Fragua@state.nm.us](mailto:Anthony.Fragua@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, Anthony Fragua at 505-231-7436 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Anthony Fragua, POC Coordinator in any of the following ways:
  - a. Electronically at [Anthony.Fragua@state.nm.us](mailto:Anthony.Fragua@state.nm.us) (*preferred method*)
  - b. Fax to 505-222-8661, or
  - c. Mail to POC Coordinator, 5301 Central Avenue NE, 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 “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:

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

## QMB Determinations of Compliance

### Compliance with Conditions of Participation

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

### Partial-Compliance with Conditions of Participation

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

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

### Non-Compliance with Conditions of Participation

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

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

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

**Introduction:**

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

**Instructions:**

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: <http://dhi.health.state.nm.us/qmb>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRC 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:** The Opportunity Center, Inc. - Southwest Region  
**Program:** Developmental Disabilities Waiver  
**Service:** 2012: *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports, Community Integrated Employment Services) and *Other* (Customized In-Home Supports)  
**Monitoring Type:** Routine Survey  
**Survey Date:** October 6 - 8, 2014

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 DDS 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 DDS;</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.</p>	<p>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 6 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 Teaching and Support Strategies</b></li> </ul> <p><i>Individual #4 - TSS not found for the following Action Steps:</i></p> <ul style="list-style-type: none"> <li>◦ Live Outcome Statement: "I want to have conversations with my family and friends"             <ul style="list-style-type: none"> <li>➢ "... will call a friend no more than every 30 minutes."</li> </ul> </li> <li>◦ Work/Education/Volunteer Outcome Statement: "... will earn 5 recognition awards in the next 5 years"             <ul style="list-style-type: none"> <li>➢ "... will have assistance to volunteer, bell ring, etc."</li> </ul> </li> <li>◦ Other Outcome Statement: "I will complete 10 art pieces"</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>Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix 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 DDSD.</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 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><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> </ul>	<ul style="list-style-type: none"> <li>➤ "... will have support to work on an art pieces each week."</li> <li>➤ "... will have support to create a portfolio with at least 10 pieces."</li> </ul> <ul style="list-style-type: none"> <li>• Positive Behavioral Support Plan (#4)</li> <li>• Behavior Crisis Intervention Plan (#3)</li> <li>• Speech Therapy Plan (#4)</li> <li>• Occupational Therapy Plan (#4)</li> <li>• <b>Vision Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #1 - As indicated by collateral documentation reviewed, exam was completed on 9/26/2013. Follow-up was to be completed in 6 months. No evidence of follow-up found.</li> </ul> </li> <li>◦ <b>Dermatologist Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #1 – As indicated by collateral documentation on 1/16/2014 was referred to Dermatologist. No results from appointment were found.</li> </ul> </li> </ul>		
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<ul style="list-style-type: none"> <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 (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);</li> <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</p>			
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<p>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> <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> <ol style="list-style-type: none"> <li>(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;</li> <li>(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);</li> <li>(3) Progress notes and other service delivery documentation;</li> <li>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</li> <li>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of</li> </ol>			
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<p>the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(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</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records 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>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<ul style="list-style-type: none"> <li>• According to the Live Outcome statement; "... will add a recipes to his cook book every week" evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2014 - 9/2014.</li> <li>• According to the Live Outcome; Action Step for "... will put her articles in her scrapbook" is to be completed 2 times per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2014 - 8/2014.</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>• According to the Relationships/Have Fun Outcome; Action Step for "... will save the minimum of \$30 dollars a month towards his vacation" is to be completed 1 time per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2014 and 9/2014.</li> <li>• According to the Relationships/Have Fun Outcome; Action Step for "... will explore vacation options online" is to be completed 1 time per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2014 and 9/2014.</li> <li>• According to the Relationships/Have Fun Outcome; Action Step for "... will explore vacation options online" is to be completed 1 times per month, evidence found indicated it was not being completed at the required</li> </ul>		
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frequency as indicated in the ISP for 6/2014 and 8/2014.

Individual #3

- According to the Work/Education/Volunteer Outcome; Action Step for "... will have support to select a variety of subjects to do editorials on and submit the editorials for publishing" is to be completed 1 time per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2014 - 8/2014.
- According to the Relationships/Have Fun; Action Step for "... will have support to purchase needed items, meet with local artists, learn different styles, and create different pieces of artwork" is to be completed 1 time per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2014 - 8/2014.

Individual #5

- According to the Work/Education/Volunteer Outcome; Action Step for "... will attend any/all monthly events with SMS (Student Media Solutions) is to be completed Bi-Weekly, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2014 - 9/2014.
- According to the Work/Education/Volunteer Outcome; Action Step for: "... will attend Flickenger events" is to be completed 1 time a quarter, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1<sup>st</sup> Quarter 2014 (April, May and June) and 2<sup>nd</sup> Quarter 2014 (July, August and September).

- According to the Relationships/Have Fun; Action Step for “will attend events in the community and get out of town” is to be completed 1 time a month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2014 - 9/2014.

- According to the Relationships/Have Fun; Action Step for “will create a scrap book of his events” is to be completed 1 time a month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2014 and 9/2014.

Individual #6

- None found regarding: Relationships/Have Fun Outcome/Action Step: “... will go out in the community to a place of her choosing” is to be completed 1 time a week, as indicated in the ISP for 7/2014 - 8/2014.
- According to the Relationships/Have Fun; Action Step for “with all needed support, ... will take photos reflective of her interests, develop them and submit them for publication” is to be completed 2 times a month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2014 - 8/2014.

**Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**

Individual #2

- None found regarding:

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|  | <ul style="list-style-type: none"><li>• Work/Education/Volunteer, Action Step:<br/>“Staff will assist ... in identifying tasks that he is interested in and capable of doing so that he proves his value at the workplace” 1 time per week for 8/2014 - 9/2014.</li></ul> |  |  |
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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><i>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</i></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>◦ Comprehensive Aspiration Risk Management Plan: <ul style="list-style-type: none"> <li>➤ Not Current (#5)</li> </ul> </li> <li>• <b>Health Care Plans</b> <ul style="list-style-type: none"> <li>◦ Constipation (#4)</li> <li>◦ Respiratory (#3)</li> </ul> </li> <li>• <b>Medical Emergency Response Plans</b> <ul style="list-style-type: none"> <li>◦ Constipation (#5)</li> </ul> </li> <li>• <b>Progress Notes/Daily Contacts Logs:</b> <ul style="list-style-type: none"> <li>◦ Individual #2 - None found for 10/2 – 6, 2014.</li> <li>◦ Individual #3 - None found for 10/1 – 5, 2014.</li> <li>◦ Individual #4 - None found for 10/1 – 5, 2014.</li> <li>◦ Individual #5 - None found for 10/1 – 5, 2014.</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> <ul style="list-style-type: none"> <li>(a) The name of the individual;</li> <li>(b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;</li> <li>(c) Diagnosis for which the medication is prescribed;</li> <li>(d) Dosage, frequency and method/route of delivery;</li> <li>(e) Times and dates of delivery;</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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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
<p><b>Service Domain: Qualified Providers</b> – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.</p>			
<p><b>Tag # 1A20</b> <b>Direct Support Personnel Training</b></p>	<p><b>Standard Level Deficiency</b></p>		
<p><b>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:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.  B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.  C. Staff shall complete training on DOH-approved 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/guidelines.  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</p>	<p>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 17 of 37 Direct Support Personnel.</p> <p>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> <li>• Pre- Service (DSP #233)</li> <li>• Foundation for Health and Wellness (DSP #233)</li> <li>• Person-Centered Planning (1-Day) (DSP #212)</li> <li>• First Aid (DSP #200, 201, 202, 207, 210, 211, 212, 213, 214, 215, 219, 220, 228, 235)</li> <li>• CPR (DSP #200, 201, 202, 207, 210, 211, 212, 213, 219, 220, 228, 235)</li> <li>• Assisting With Medication Delivery (DSP #202, 208, 214, 215, 216)</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>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.</p> <p>H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.</p> <p>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.</p> <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>G. Training Requirements: 1.</b> All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy.</p> <p><b>CHAPTER 6 (CCS) 3. Agency Requirements</b></p> <p><b>F. Meet all training requirements as follows:</b></p> <p><b>1.</b> All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;</p> <p><b>CHAPTER 7 (CIHS) 3. Agency Requirements</b></p> <p><b>C. Training Requirements:</b> The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy</p>			
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<p><b>CHAPTER 11 (FL) 3. Agency Requirements</b>  <b>B. Living Supports- Family Living Services</b>  <b>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 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>  <b>B. Living Supports- Supported Living Services</b>  <b>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</p>			
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the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

**CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.** 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>status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training.</p> <p><b>CHAPTER 11 (FL) 3. Agency Requirements</b>  <b>B. Living Supports- Family Living Services</b>  <b>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</p>	<p><b>When DSP were asked if the Individual had a Positive Behavioral Supports Crisis Plan and if so, what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #222 stated, "I don't know." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Crisis Plan. (Individual #3)</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 #222 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #5)</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 #207 stated, "No they don't have it." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #5)</li> <li>• DSP #222 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #5)</li> </ul> <p><b>When DSP were asked if the Individual had a Comprehensive Aspiration Risk Management Plan and if so, what the plan covered, the following was reported:</b></p>		
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<p>Documentation for DDSD Training Requirements.</p> <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.</p>	<ul style="list-style-type: none"> <li>• DSP #207 stated, "Read through when I started but that was a while back, unsure of plan." According to the Individual Specific Training Section of the ISP, the Individual requires a Comprehensive Aspiration Risk Management Plan. (Individual #5)</li> <li>• DSP #222 stated, "I'm not aware of any." According to the Individual Specific Training Section of the ISP, the Individual requires a Comprehensive Aspiration Risk Management Plan. (Individual #5)</li> </ul> <p><b>When DSP were asked if the Individual had a Dietary and/or Nutritional Requirements and if so, what the plan(s) covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #217 stated, "No she's normal." As indicated by the Individual Specific Training section of the ISP indicates the Individual requires a Nutritional Plan. (Individual #6)</li> </ul> <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 #217 stated, "Falls." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for Shunt and Seizures (Individual #6).</li> <li>• DSP #222 stated, "Seizures, Respiratory, Pain, that's it rest are duplicates." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for Falls and Skin and Wound. (Individual #3)</li> </ul>		
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<p>B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc), and information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.</p> <p><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>	<ul style="list-style-type: none"> <li>• DSP #222 stated, "Legally blind, CP, Scoliosis, Spastic quadriplegia, neurogenic bowel." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care plans for Body Mass Index, Constipation and Skin and Wound. (Individual #4)</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> <ul style="list-style-type: none"> <li>• DSP #207 stated, "Aspiration, Seizures and Falls." As indicated by the Individual Specific Training section of the ISP indicates the Individual also requires Medical Emergency Response Plans for: Respiratory. (Individual #5)</li> <li>• DSP #217 stated, "Seizures, Sinus Tachycardia. If she falls check her out call office and do an IR on it." As indicated by the Individual Specific Training section of the ISP the Individual additionally requires Medical Emergency Response Plans for: Shunt implant, Hypertension, Falls. (Individual #6)</li> </ul> <p><b>When DSP were asked if the Individual had Dehydration and if so, what are they to monitor, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #204 stated, "Not that I know of." According to the Health and Safety Section of the ISP the Individual is to have a minimum of 8 glasses of water a day in the winter and 12 in the summer. (Individual #2)</li> </ul>		
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	<p><b>When DSP were asked what are the signs and symptoms of Dehydration, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #222 stated, "High Blood Pressure." Per documentation reviewed individual was seen in the Emergency Room for Dehydration 9/3/2014. DSP #222 did not discuss symptoms of dehydration. (Individual #3)</li> </ul> <p><b>When DSP were asked to describe how new staff are trained on what to do if there is a seizure, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #207 stated, "Review Health Care Plans on the Job, no training." According to the IST, training should be completed by the "Opportunity Center Staff". (Individual #5)</li> <li>• DSP #218 stated, "I read a packet." According to the IST, training should be completed by the "Nurse-Opportunity Center". (Individual #3)</li> </ul>		
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<p>employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</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	Standard 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>Based on interview, the Agency did not ensure Incident Management Training for 2 of 38 Agency Personnel.</p> <p><b>When Direct Support Personnel were asked what State Agency must be contacted when there is suspected Abuse, Neglect and exploitation of Consumers' Property, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #209 stated, "We give it to... (#239) then they send it in." Staff was not able to identify the Agency as Division of Health Improvement or DHI.</li> <li>• DSP #218 stated, "I'm drawing a blank." Staff was not able to identify the Agency as Division of Health Improvement or DHI.</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>			
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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</b></p> <p><b>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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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
<p><b>Service Domain: Health and Welfare</b> – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.</p>			
<p><b>Tag # 1A03 CQI System</b></p>	<p><b>Standard Level Deficiency</b></p>		
<p><b>STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS</b>  d. PROVIDER shall have a Quality Management and Improvement Plan in accordance with the current MF Waiver Standards and/or the DD Waiver Standards specified by the DEPARTMENT. The Quality Management and Improvement Plan for DD Waiver Providers must describe how the PROVIDER will determine that each waiver assurance and requirement is met. The applicable assurances and requirements are: (1) level of care determination; (2) service plan; (3) qualified providers; (4) health and welfare; (5) administrative authority; and, (6) financial accountability. For each waiver assurance, this description must include:</p> <ol style="list-style-type: none"> <li>i. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance;</li> <li>ii. The entities or individuals responsible for conducting the discovery/monitoring processes;</li> <li>iii. The types of information used to measure performance; and,</li> <li>iv. The frequency with which performance is measured.</li> </ol>	<p>Based on record review and interview, the Agency had not fully implemented their Continuous Quality Management System as required by standard.</p> <ul style="list-style-type: none"> <li>• Review of the findings identified during the on-site survey October 6 - 8, 2014 and as reflected in this report of findings, the Agency had multiple deficiencies noted, including Conditions of Participation out of compliance, which indicates the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.</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><b>CHAPTER 5 (CIES) 3. Agency Requirements: 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 effectiveness of such implementation as indicated by achievement of outcomes;</p>			
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<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 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. 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 DDSD 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> <p><b>CHAPTER 6 (CCS) 3. Agency Requirements: 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</p>			
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<p>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> <ol style="list-style-type: none"> <li>a. The extent to which services are delivered in accordance with ISPs, associated support plans and WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;</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 of reportable incidents; and</li> <li>g. Results of improvement actions taken in previous quarters.</li> </ol>			
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<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> <ol 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> </ol> <p><b>CHAPTER 7 (CIHS) 3. Agency Requirements: 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</p>			
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<p>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 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> <ul style="list-style-type: none"> <li>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 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 of reportable incidents; and</li> <li>g. Results of improvement actions taken in previous quarters.</li> </ul> <p><b>3.</b> 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</p>			
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<p>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 and associated support plans and/or 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 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</li> <li>g. Significant program changes.</li> </ul> <p><b>CHAPTER 11 (FL) 3. Agency Requirements: 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</p>			
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<p>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 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><b>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:</b></p> <ul style="list-style-type: none"> <li>a. Sufficiency of staff coverage;</li> </ul>			
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<p>b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes;</p> <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 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. 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><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</p>			
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<p>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 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 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>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 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> <li>d. Patterns in medication errors;</li> </ul>			
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<p>e. Action taken regarding individual grievances;  f. Presence and completeness of required documentation;  g. A description of how data collected as part of the agency's QA/QI plan was used, what quality improvement initiatives were undertaken, and the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and  h. Significant program changes.</p> <p><b>CHAPTER 13 (IMLS) 3. Service Requirements:</b>  <b>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 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</p>			
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<p>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. 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> </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 DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:</p> <ol style="list-style-type: none"> <li>a. Sufficiency of staff coverage;</li> <li>b. Effectiveness and timeliness of implementation of ISPs and associated Support plans and/or WDSI including trends in achievement of individual desired outcomes;</li> <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> </ol>			
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<p>h. Significant program changes.</p> <p><b>CHAPTER 14 (ANS) 3. Service Requirements:</b></p> <p><b>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 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 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>Trends in General Events as defined by DDSD;</li> <li>Compliance with Caregivers Criminal History Screening Requirements;</li> <li>Compliance with DDSD training requirements;</li> <li>Trends in reportable incidents; and</li> </ol>			
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<p>e. 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 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. 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 discovery and remediation of any service delivery deficiencies discovered through the QI process; and</li> <li>g. Significant program changes</li> </ul> <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></p> <p>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</p>			
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<p>the following internal monitoring and facilitating quality improvement program:</p> <ul style="list-style-type: none"> <li>(1) community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements;</li> <li>(2) community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and</li> <li>(3) 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.</li> </ul>			
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mental health of individuals and which comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.

<b>Tag # 1A09</b> <b>Medication Delivery</b> <b>Routine Medication Administration</b>	<b>Standard Level Deficiency</b>		
<p><b>NMAC 16.19.11.8 MINIMUM STANDARDS:</b>  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, <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 month of September and October 2014.</p> <p>Based on record review, 5 of 5 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</p> <p>Individual #2  September 2014  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Ativan (Loazepam) 1mg (3 times daily) – Blank 9/24 (2:00 PM).</li> <li>• Baclofen 5mg (2 times daily) – Blank 9/29 and 30 (8:00 PM).</li> <li>• Zadorin 1 drop in each eye (2 times daily) – Blank 9/20 (8:00 AM).</li> </ul> <p>October 2014  Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Cogentin .5mg (2 times daily)</li> </ul> <p>Individual #3  September 2014  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Ensure 1 Can (2 times daily) – Blank 9/2, 4, 10, 11 (8:00 AM); 9/1, 3, 4, 5, 9, 10, 11 and 12 (4:00 PM).</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>➤ 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>• Provachol (Pravastatin) 40mg (1 time daily) – Blank 9/2 (8:00 PM).</li> <li>• Zonegran (Zonisamide) 100mg (2 times daily) – Blank 9/11 (8:00 PM)</li> </ul> <p>October 2014 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Calmoseptine Ointment (2 times daily) – Blank 10/1, 2, 3 (8:00 AM); 10/1, 2 (8:00 PM)</li> </ul> <p>As indicated by the Medication Administration Records the individual is to take Omeprazole 20mg capsule (1 time daily). According to the Physician's Orders, Omeprazole 20mg capsule is to be taken 2 times daily Medication Administration Record and Physician's Orders do not match.</p> <p>As indicated by the Medication Administration Records the individual is to take Natures Tears 1 drop in each eye (2 times daily). According to the Physician's Orders, Artifi Tears Sol OP 1 drop in each eye (Natures Tears) is to be taken 4 times daily Medication Administration Record and Physician's Orders do not match.</p> <p>Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>• Zaditor 1 drop each eye (2 times daily)</li> </ul> <p>Individual #4 September 2014</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.</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.</p> <p><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 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>• Nitrofurantoin 100 mg (1 time daily) – Blank 9/7 (8:00 PM).</li> <li>• Psyllium 2-4 unit dose (1 time daily) – Blank 9/2 (8:00 AM).</li> </ul> <p>October 2014</p> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Cipro 500mg (2 times daily) – Blank 10/2, 4, 5 (8:00 AM); 10/3, 4 (8:00 PM).</li> </ul> <p>Individual #5</p> <p>September 2014</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Atarax 10 mg (3 times daily).</li> </ul> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Ensure 1 Can (2 times daily) – Blank 9/1, 2, 4, 5, 9, 11,12 (10:00 AM); 9/1, 2, 4, 9, 11, and 11 (3:30 PM).</li> <li>• Olive Oil or Canola Oil 1 TBSP (3 times daily) – Blank 9/1 - 30, 2014.</li> </ul> <p>Medication Administration Record did not contain the time the medication should be given. MAR indicated time as "AM, PM and/or Bedtime":</p> <ul style="list-style-type: none"> <li>• Olive Oil or Canola Oil 1 TBSP (3 times daily).</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>	<p>October 2014 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Atarax (Hydroxyz HCL) 10 mg (3 times daily)</li> </ul> <p>As indicated by the Medication Administration Records the individual is to take Atarax (Hydroxyz HCL) 10 mg (3 times daily). According to the Physician's Orders, Hydroxyz HCL 25 mg is to be taken 3 times daily Medication Administration Record and Physician's Orders do not match.</p> <p>Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>• Olive Oil or Canola Oil 1 TBSP (3 times daily).</li> <li>• Zaditor 1 drop each eye (2 times daily)</li> </ul> <p>Individual #6 October 2014 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Depakote ER 500 mg (1 time daily)</li> <li>• Tegretol ER 200 mg (1 time daily)</li> <li>• Zyprexa 10 mg (1 time daily)</li> </ul> <p>Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:</p> <ul style="list-style-type: none"> <li>• Coreg 3.125 mg (2 times daily)</li> </ul>		
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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>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>	<ul style="list-style-type: none"> <li>• Divalproex (Depakote) (1 times daily)</li> <li>• Lactobacillus Rhamnosus 80mg (2 times daily)</li> <li>• Lactulose 15ml (2 times daily)</li> </ul>		
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<p>b. 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>c. 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>d. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service</p>			
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<p>locations and must include the expected desired outcomes of administrating 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</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b></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> <p>(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>			
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<p>diagnosis for which the medication is prescribed;</p> <p>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <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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- 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**

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>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 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>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 DDSD 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>e. 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>f. 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>g. 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>h. 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><b>Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003</b></p> <p><b>IV. POLICY STATEMENT</b> - 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.</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</p>			
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<p>five years from the completion of each individual's Individual Service Plan.</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>  <b>B. 1. e.</b> 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>			
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Tag #1A31.1 Human Rights Policy & Procedures	Standard Level Deficiency		
<p><b>Long Term Services Division</b>  <b>Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003</b>  <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>            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>Based on record review, the Agency did not follow DDSD Policy regarding Human Rights Committee Requirements.</p> <p>Review of the Agency Policy and Procedure found the policy did not address restrictions or limitation of client's rights approved by the Human Rights Committee are to be reviewed at least quarterly.</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>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> <p><b>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:</b></p> <p>A. A service provider shall not restrict or limit a client's rights except:</p> <p>(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</p> <p>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</p> <p>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</p> <p>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.</p> <p>C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do</p>			
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not violate client rights. [09/12/94; 01/15/97;  
Recompiled 10/31/01]

**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><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 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> <p>(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.</p>			
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<p>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.</p> <p>(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.</p> <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>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>a. Maintain basic utilities, i.e., gas, power, water, and telephone;</p> <p>b. 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>c. Ensure water temperature in home does not exceed safe temperature (110° F) ;</p> <p>d. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system;</p> <p>e. Have a general-purpose First Aid kit;</p> <p>f. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and</p>			
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<p>each individual has the right to have his or her own bed;</p> <p>g. 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>h. 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>i. 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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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
<b>Service Domain: Medicaid Billing/Reimbursement</b> – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.			
<b>Tag # IS30</b> <b>Customized Community Supports Reimbursement</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 6 (CCS) 4. REIMBURSEMENT A. Required Records:</b> All Provider Agencies 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 Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, nature of services, and length of a session of service billed.</p> <p>1. 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 Human Services Department (HSD). For each unit billed, the record shall contain the following:</p> <p>a. Date, start and end time of each service encounter or other billable service interval;</p> <p>b. A description of what occurred during the encounter or service interval; and</p> <p>c. The signature or authenticated name of staff providing the service.</p> <p><b>B. Billable Unit:</b></p>	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 2 of 5 individuals.</p> <p>Individual #2 July 2014</p> <ul style="list-style-type: none"> <li>The Agency billed 10 units of Customized Community Supports (group) (T2021 HB U7) on 7/9/2014. Documentation received accounted for 8 units.</li> <li>The Agency billed 9 units of Customized Community Supports (group) (T2021 HB U7) on 7/10/2014. Documentation received accounted for 2 units.</li> </ul> <p>Individual #3 June 2014</p> <ul style="list-style-type: none"> <li>The Agency billed 24 units of Customized Community Supports (group) (T2021 HB U7) on 6/19/2014. Documentation received accounted for 16 units.</li> <li>The Agency billed 24 units of Customized Community Supports (group) (T2021 HB U7) on 6/24/2014. Documentation received accounted for 14 units.</li> </ul> <p>July 2014</p> <ul style="list-style-type: none"> <li>The Agency billed 17 units of Customized Community Supports (group) (T2021 HB</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>  </p>

<ol style="list-style-type: none"> <li>1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit.</li> <li>2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit.</li> <li>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.</li> <li>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 DDSD.</li> <li>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).</li> <li>6. The billable unit for Fiscal Management for Adult Education is dollars charged for each class including a 10% administrative processing fee.</li> </ol> <p><b>C. Billable Activities:</b></p> <ol style="list-style-type: none"> <li>1. All DSP activities that are: <ol style="list-style-type: none"> <li>a. Provided face to face with the individual;</li> <li>b. Described in the individual's approved ISP;</li> <li>c. Provided in accordance with the Scope of Services; and</li> </ol> </li> </ol>	<p>U7) on 7/8/2014. Documentation received accounted for 15 units.</p>		
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<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 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>			
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<p><b>B. Billable Units:</b> The billable unit for Customized In-Home Support is based on a fifteen (15) minute unit.</p> <p><b>C. Billable Activities:</b></p> <ol style="list-style-type: none"> <li>1. Direct care provided to an individual in the individual's residence, consistent with the Scope of Services, any portion of the day.</li> <li>2. Direct support provided to an individual consistent with the Scope of Services by Customized In-Home Supports direct support personnel in community locations other than the individual's residence.</li> </ol>			
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Date: February 17, 2015

To: Christina Martinez, Executive Director  
Provider: The Opportunity Center, Inc.  
Address: 905 Tenth Street  
State/Zip: Alamogordo, New Mexico 88310

E-mail Address: [christina\\_oppcenter@hotmail.com](mailto:christina_oppcenter@hotmail.com)

CC: Philip Gutierrez, President of the Board  
Address: 1300 N. White Sands  
State/Zip: Alamogordo, New Mexico 88310

Vice President: Dr. Norman Lindley  
E-Mail Address: [elmedico23@hotmail.com](mailto:elmedico23@hotmail.com)

Region: Southwest  
Survey Date: October 6 - 8, 2014  
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012: Living Supports** (Supported Living); **Inclusion Supports** (Customized Community Supports, Community Integrated Employment Services) and **Other** (Customized In-Home Supports)

Survey Type: Routine

Dear Ms. Martinez:

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.

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, your case will 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,

*Tony Fragua*

Tony Fragua  
Health Program Manager/Plan of Correction Coordinator



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Date: May 6, 2015

To: Christina Martinez, Executive Director  
Provider: The Opportunity Center, Inc.  
Address: 905 Tenth Street  
State/Zip: Alamogordo, New Mexico 88310

E-mail Address: [christina\\_oppcenter@hotmail.com](mailto:christina_oppcenter@hotmail.com)

CC: Philip Gutierrez, President of the Board  
Address: 1300 N. White Sands  
State/Zip: Alamogordo, New Mexico 88310

Vice President: Dr. Norman Lindley  
E-Mail Address: [elmedico23@hotmail.com](mailto:elmedico23@hotmail.com)

Region: Southwest  
Routine Survey: October 6 - 8, 2014  
Verification Survey: March 31, 2015  
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012: Living Supports** (Supported Living); *Inclusion Supports* (Customized Community Supports, Community Integrated Employment Services) and *Other* (Customized In-Home Supports)

Survey Type: Verification

Dear Ms. Martinez:

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

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

Sincerely,

*Tony Fragua*

Tony Fragua  
Health Program Manager/Plan of Correction Coordinator  
Quality Management Bureau/DHI

Q.15.3.DDW.D1556.3.VER.09.15.126