Date:	March 7, 2018
To:	Eleanor Sanchez, Assistant Director
Provider:	Progressive Residential Services of New Mexico, Inc.
Address:	1100 S. Main Street, Suite A
State/Zip:	Las Cruces, New Mexico 88005
E-mail Address:	esanchez@prs-nm.org
Region:	Southwest Region
Survey Date:	October 13 - 19, 2017
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	**2007:** Supported Living, Adult Habilitation, **2012:** Supported Living, Customized Community Supports, Customized In-Home Supports
Survey Type:	Routine Survey
Team Leader:	Chris Melon, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Barbara Kane, BAS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Amanda Castaneda, MPA, Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau; Anthony Fragua, BFA, Health Program Manager, Division of Health Improvement/Quality Management Bureau and Michele Beck, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Eleanor Sanchez;

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

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

Partial Compliance with Conditions of Participation

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

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

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

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

During the exit interview of your on-site survey Attachment A on the Plan of Correction Process was provided to you. Please refer to Attachment A for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

Corrective Action:

- How is the deficiency going to be corrected? (i.e. obtained documents, retrain staff, individuals and/or staff no longer in service, void/adjusts completed, etc.) This can be specific to each deficiency cited or if possible an overall correction, i.e. all documents will be requested and filed as appropriate.

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done? (i.e. file reviews, periodic check with checklist, etc.)
- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORI, etc.)

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

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

1. **Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator 1170 North Solano Suite D Las Cruces, New Mexico 88001**

2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

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

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

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

Attention: Lisa Medina-Lujan
HSD/OIG
Program Integrity Unit
2025 S. Pacheco Street
Santa Fe, New Mexico 87505

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

Attention: Lisa Medina-Lujan
HSD/OIG
Program Integrity Unit
1474 Rodeo Road
Santa Fe, New Mexico 87505

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

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

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

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

Please call the Plan of Correction Coordinator Amanda Castaneda at 575-373-5716 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Chris Melon, MPA

Chris Melon, MPA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	October 13, 2017
Contact:	**Progressive Residential Services of New Mexico, Inc.** Melissa Alvarez-Ortega, Executive Director **DOH/DHI/QMB** Chris Melon, MPA, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	October 16, 2017
Present:	**Progressive Residential Services of New Mexico, Inc.** Melissa Alvarez-Ortega, Executive Director Chance Barrett, Office Assistant **DOH/DHI/QMB** Chris Melon, MPA, Team Lead/Healthcare Surveyor Anthony Fragua, BFA, Health Program Manager Michele Beck, Healthcare Surveyor
Exit Conference Date:	October 19, 2017
Present:	**Progressive Residential Services of New Mexico, Inc.** Melissa Alvarez-Ortega, Executive Director Jessica Manning, LPN Elizabeth Flores, Day Service Coordinator Alonso Magallanes, Day Service Site Lead Mark Jenkins, Residential Service Coordinator / Incident Management Coordinator Irene Gonzales, Medical Assistant Chance Barrett, Office Assistant **DOH/DHI/QMB** Chris Melon, MPA, Team Lead/Healthcare Surveyor Anthony Fragua, BFA, Health Program Manager Amanda Castaneda, MPA, Plan of Correction Coordinator Michele Beck, Healthcare Surveyor **DDSD Southwest Regional Office** Angie Brooks, Generalist
Administrative Locations Visited	1
Total Sample Size	9 2 - *Jackson* Class Members 7 - Non-*Jackson* Class Members 8 - Supported Living 2 - Adult Habilitation 6 - Customized Community Supports 1 - Customized In-Home Supports
Total Homes Visited	7

❖ Supported Living Homes Visited	7
	Note: The following Individuals share a SL residence: ➢ #3, 8
Persons Served Records Reviewed	9
Persons Served Interviewed	5
Persons Served Observed	3 (these individuals chose not to participate in the interview process)
Persons Served Not Seen and/or Not Available	1
Direct Support Personnel Interviewed	12
Direct Support Personnel Records Reviewed	83
Service Coordinator Records Reviewed	2
Administrative Interviews	2

Administrative Processes and Records Reviewed:

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

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

Attachment A

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

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

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

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

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. 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.

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
    a. Electronically at AmandaE.Castaneda@state.nm.us *(preferred method)*
    b. Fax to 575-528-5019, or
    c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”
    a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
    b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
    c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

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

1. Your internal documents are due within a ***maximum*** of 45 business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).
3. All submitted documents ***must be annotated***; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. 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.

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 the following Service Domains.

Case Management Services *(Four Service Domains)*:

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

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

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

Conditions of Participation (CoPs)

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

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

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

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

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

Service Domain: Plan of Care ISP Development & Monitoring

Condition of Participation:

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

Condition of Participation:

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

Service Domain: Level of Care

Condition of Participation:

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

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

Service Domain: Qualified Providers

Condition of Participation:

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

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

Service Domain: Service Plan: ISP Implementation

Condition of Participation:

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

Service Domain: Health, Welfare and Safety

Condition of Participation:

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

Condition of Participation:

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

QMB Determinations of Compliance

Compliance with Conditions of Participation

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

Partial-Compliance with Conditions of Participation

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

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

Non-Compliance with Conditions of Participation

The QMB determination of *Non-Compliance with Conditions of Participation* indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains and/or 6 or more Condition of Participation level deficiencies overall, as well as widespread Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

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

Attachment C

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

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

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

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

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

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

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

Agency: **Progressive Residential Services of New Mexico, Inc. - Southwest Region**
Program: Developmental Disabilities Waiver
Service: ***2007:*** Supported Living, Adult Habilitation
2012: Supported Living, Customized Community Supports, Customized In-Home Supports
Monitoring Type: Routine Survey
Survey Date: **October 13 - 19, 2017**

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Service Plans: ISP Implementation - *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08 Agency Case File	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **Chapter 5 (CIES) 3. Agency Requirements: J. Consumer Records Policy:** Community Integrated Employment 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. **Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. Additional documentation that is required to be maintained at the administrative office includes: 1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD.	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 9 Individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Current Emergency and Personal Identification Information:** • None Found (#9) • Did not contain current phone number (#3) **Positive Behavioral Support Plan** • Not Current (#3) **Speech Therapy Plan** • Not Current (#5)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy: 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. **Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy:** 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. **Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy:** 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. **Chapter 13 (IMLS) 2. Service Requirements: 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) • Emergency contact information; • Personal identification; • ISP budget forms and budget prior authorization; • 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); • 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; • Copy of Guardianship or Power of Attorney documents as applicable; • Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays; • Written consent by relevant health decision maker and primary care practitioner for self-administration of medication or assistance with medication from DSP as applicable; • Progress notes written by DSP and nurses; • Signed secondary freedom of choice form; • Transition Plan as applicable for change of provider in past twelve (12) months. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications:** 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. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. **NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.			

Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	Condition of Participation Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan for 8 of 9 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • According to the Live Outcome; Action Step for "...will shop for his items" 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 7/2017. • According to the Live Outcome; Action Step for "...will purchase his items" is to be completed monthly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2017 - 8/2017. Individual #3 • According to the Live Outcome; Action Step for "...will work on her project" is to be completed weekly. Evidence found	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

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]	indicated it was not being completed at the required frequency as indicated in the ISP for 7/2017 - 9/2017. Individual #4 • According to the Live Outcome; Action Step for "...will work on item" is to be completed weekly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2017. Individual #7 • According to the Live Outcome; Action Step for "...will treasure hunt" 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 7/2017 - 9/2017. • According to the Live Outcome; Action Step for "...will collect/display items in his room" 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 7/2017. Individual #9 • According to the Live Outcome; Action Step for "...will plant/care for her garden" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2017 - 8/2017. **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #8 • None found regarding: Work/learn Outcome/Action Step: "...will pick what		

	actions step she wants to do" for 7/2017 - 9/2017. Action step is to be completed 3 times per week. • None found regarding: Work/learn Outcome/Action Step: "...will participate in the exercise she chose" for 7/2017 - 9/2017. Action step is to be completed 3 times per week. **Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #6 • According to the Live Outcome; Action Step for "...will use public transportation to get to a place of his choice" is to be completed weekly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2017 - 9/2017. • According to the Live Outcome; Action Step for "...will use public transportation" is to be completed monthly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2017. **Residential Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes** Individual #1 • None found regarding: Live Outcome/Action Step: "...will shop for his items" for 10/1 - 10/13, 2017. Action step is to be completed 1 time per week.		

	Individual #3 • None found regarding: Live Outcome/Action Step: "...will work on grocery list" for 10/1 - 10/13, 2017. Action step is to be completed weekly. Individual #4 • None found regarding: Live Outcome/Action Step: "...will work on item" for 10/1 - 10/13, 2017. Action step is to be completed weekly. Individual #5 • None found regarding: Live Outcome/Action Step: "…will research upcoming events" for 10/1 - 10/13, 2017. Action step is to be completed 2 times per week. Individual #7 • None found regarding: Live Outcome/Action Step: "...collects/displays items in his room" for 10/1 - 10/13, 2017. Action step is to be completed 1 time per week. Individual #8 • None found regarding: Live Outcome/Action Step: "...will look on internet, magazines, or the internet to find things she would like to buy/make" for 10/1 - 10/13, 2017. Action step is to be completed 1 time per week. Individual #9 • None found regarding: Fun Outcome/Action Step: "...will plan her trips" for 10/1 - 10/13, 2017. Action step is to be completed 1 time per week.		

Tag # IS11 / 5I11 Reporting Requirements Inclusion Reports	Standard Level Deficiency		
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 5 (CIES) 3. Agency Requirements:** **I. Reporting Requirements:** The Community Integrated Employment Agency must submit the following: 1. Progress Reports**:** Community Integrated Employment Services providers must submit written status reports to the individual's Case Manager and other IDT members. When reports are developed in any language other	Based on record review, the Agency did not complete written status reports as required for 1 of 8 individuals receiving Inclusion Services. **Adult Habilitation Quarterly Reports:** Individual #5 - None found for 8/2016 - 10/2016. *(Term of ISP 5/1/2016 - 4/30/2017).*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

than English, it is the responsibility of the provider to translate the reports into English. These reports are due at two points in time: a mid-cycle report due on day 190 of the ISP cycle and a second summary report due two weeks prior to the annual ISP meeting that covers all progress since the beginning of the ISP cycle up to that point. These reports must contain the following written documentation: a. Written updates to the ISP Work/Learn Action Plan annually or as necessary due to change in work outcome to the case manager. These updates do not require an IDT meeting unless changes requiring team input need to be made (e.g., adding more hours to the Community Integrated Employment budget); and b. Written annual updates to the ISP work/learn action plan to DDSD. 2. VAP or other assessment profile to the case manager if completed externally to the ISP; 3. initial ISP reflecting the Vocational Assessment or other assessment profile or the annual ISP with the updated VAP integrated or a copy of an external VAP if one was completed to DDSD; and 4. Reports as requested by DDSD to track employment outcomes. **CHAPTER 6 (CCS) 3. Agency Requirements:** **I. Reporting Requirements:** Progress Reports**:** Customized Community Supports providers must submit written status reports to the individual's Case Manager and other IDT members. When reports are developed in any			

language other than English, it is the responsibility of the provider to translate the reports into English. These reports are due at two points in time: a mid-cycle report due on day 190 of the ISP cycle and a second summary report due two weeks prior to the annual ISP meeting that covers all progress since the beginning of the ISP cycle up to that point. These reports must contain the following written documentation: 2. Semi-annual progress reports one hundred ninety (190) days following the date of the annual ISP, and 14 days prior to the annual IDT meeting: a. Identification of and implementation of a Meaningful Day definition for each person served; b. Documentation for each date of service delivery summarizing the following: i. Choice based options offered throughout the day; and ii. Progress toward outcomes using age appropriate strategies specified in each individual's action steps in the ISP, and associated support plans/WDSI. c. Record of personally meaningful community inclusion activities; d. Written updates, to the ISP Work/Learn Action Plan annually or as necessary due to change in work outcomes. These updates do not require an IDT meeting unless changes requiring team input need to be made; and			

e. Data related to the requirements of the Performance Contract to DDSD quarterly. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **E. Provider Agency Reporting Requirements:** All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events;			

(5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD.			

Tag # LS14 / 6L14 Residential Case File	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. **CHAPTER 12 (SL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. **CHAPTER 13 (IMLS) 2. Service Requirements B.1. Documents to Be Maintained in The Home:** a. Current Health Passport generated through the e-CHAT section of the Therap website and printed for use in the home in case of disruption in internet access; b. Personal identification; c. Current ISP with all applicable assessments, teaching and support strategies, and as applicable for the consumer, PBSP, BCIP, MERP, health care plans, CARMPs, Written Therapy Support Plans, and any other plans	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 6 of 8 Individuals receiving Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Teaching and Supports Strategies:** • *Individual #3 - TSS not found for the following Live Outcome Statement / Action Steps:* • "...will work on grocery list." • "...will shop with her list." **Comprehensive Risk Management Plan:** • Not Found (#2) • Not Current (#3) **Health Care Plans:** • Aggression (#7) • Anticonvulsant Medication (#7) • Aspiration (#3) • Bowell and Bladder (#7) • Constipation (#4) • Falls (#7) • Oral Care (#7) • Psychotropic Medication (#7) • Reflux (#4) • Seizures (#7) **Medical Emergency Response Plans:** • Allergies (#9) • Constipation (#4) • Seizures (#7) **Special Healthcare Needs:** • Nutritional Plan (#8)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

(e.g. PRN Psychotropic Medication Plans) as applicable; d. Dated and signed consent to release information forms as applicable; e. Current orders from health care practitioners; f. Documentation and maintenance of accurate medical history in Therap website; g.Medication Administration Records for the current month; h. Record of medical and dental appointments for the current year, or during the period of stay for short term stays, including any treatment provided; i. Progress notes written by DSP and nurses; j. Documentation and data collection related to ISP implementation; k. Medicaid card; l. Salud membership card or Medicare card as applicable; and m. A Do Not Resuscitate (DNR) document and/or Advanced Directives as applicable. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012** **III. Requirement Amendments(s) or Clarifications:**	**Progress Notes/Daily Contacts Logs:** • Individual #9 - None found for 10/9 – 15, 2017 (date of visit: 10/17/2017)		

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. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. ***Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007*** **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone			

numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioner's prescription including the brand and generic name of the medication;			

(c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses			

including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.			

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Qualified Providers - *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A11.1 Transportation Training	**Standard Level Deficiency**		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy **Eff. Date:** March 1, 2007 **II. POLICY STATEMENTS:** I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role)	Based on record review, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 1 of 83 Direct Support Personnel. **No documented evidence was found of the following required training:** • Transportation (DSP #557)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency) **NMAC 7.9.2 F. TRANSPORTATION: (1)** Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training program in passenger transportation assistance before assisting any resident. The passenger transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of equipment, familiarity with state regulations governing the transportation of persons with disabilities, and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed. **(2)** Any employee or agent of a regulated facility or agency who drives a motor vehicle provided by the facility or agency for use in the transportation of clients must complete: **(a)** A state approved training program in passenger assistance and (**b)** A state approved training program in the operation of a motor vehicle to transport clients of a regulated facility or agency. The motor vehicle transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of motor vehicles, familiarity with state regulations governing the transportation of persons with disabilities, maintenance and safety record keeping, training on hazardous			

driving conditions and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed. **(c)** A valid New Mexico driver's license for the type of vehicle being operated consistent with State of New Mexico requirements. **(3)** Each regulated facility and agency shall establish and enforce written polices (including training) and procedures for employees who provide assistance to clients with boarding or alighting from motor vehicles. **(4)** Each regulated facility and agency shall establish and enforce written polices (including training and procedures for employees who operate motor vehicles to transport clients. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. **CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1.** All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;			

CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** 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. **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;			

Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on 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	Based on record review, the Agency did not ensure Orientation and Training requirements were met for 4 of 83 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed as required: **ISP Person-Centered Planning (1-Day):** • Not Found (#546) **First Aid:** Expired (#559) **CPR:** Expired (#559) **Participatory Communication and Choice Making:** • Not Found (#559) **Advocacy 101:** • Not Found (#503) **Positive Behavior Supports Strategies:** • Not Found (#503, 579) **Teaching and Support Strategies** • Not Found (#503, 559)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001. I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. **CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1.** All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy; **CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:** The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider			

Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** 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. **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;			

Tag # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment. **CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1.** All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interviews, the Agency did not ensure training competencies were met for 7 of 12 Direct Support Personnel. **When DSP were asked if they received training on the individual's Behavioral Crisis Intervention Plan and if so, what the plan covered, the following was reported:** • DSP #545 stated, "No, I didn't find it." According to the Individual Specific Training Section of the ISP, the individual has a Behavioral Crisis Intervention Plan. (Individual #9) **When DSP were asked if the individual required physical restraint, such as MANDT, CPI or Handle with Care, and if so, had they received training to perform the restraint safely, the following was reported:** • DSP #531 "I don't know, I've never heard of them." According to the Individuals "Behavior Intervention and Crisis Plan", the use of restraints is to be used if there is harm to self or others. (Individual #9) • DSP #566 "If he is going to be a harm to himself, then yes." According to the Individual's Positive Behavior Support Plan, he does not require physical restraint. (Individual #1) **When DSP were asked if they received training on the individual's Health Care Plans**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training. **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living 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	**and if so, what the plan(s) covered, the following was reported:** • DSP #513 stated, "... has Diabetes and Falls." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for Constipation, Pain and Reflux. (Individual #4) • DSP #545 stated, "Aspiration, BMI, PRN Psych Meds and Falls." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Status of Care/Hygiene. (Individual #8) • DSP #545 stated, "Neuro Device Implant, Seizures, Constipation, PRN meds, Falls and that's it." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Status of Care/Hygiene. (Individual #9) • DSP #549 stated, "Just his footwear, needs to remain injury free." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Seizure and Constipation. (Individual #7) **When DSP were asked if the Individual had any allergies that could be potentially life threatening, the following was reported:** • DSP #531 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the individual is allergic to Sulfa Medications. (Individual #9)		

report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc), information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** 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	**When DSP were asked if they received training on the individual's Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:** • DSP #513 stated, "… has Diabetes, Low Fat Diet, Fall, Injuries, just these three." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for Constipation. (Individual #4) • DSP #555 stated, "Seizures." the Individual Specific Training section of the ISP indicates the Individual also requires a Medical Emergency Response Plan for Oral Hygiene Protocol. (Individual #7) **When DSP were asked if they tracked bowel movements, the following was reported:** • DSP #555 stated, "No." As indicated by the Individual Training section of the ISP. The Individual requires Health Care Plans for Toileting, Bowel Function and Constipation. Residential staff are to track the Individual's bowel movements. (Individual #7) **When DSP were asked to describe how new staff are trained on what to do if the Individual experiences a seizure, the following was reported:** • DSP #547 stated, "SLP or Site Lead." As indicated by the Individual Specific Training section of the ISP, Day Support staff are		

must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. B Individual specific training must be arranged and conducted, including training on the ISP 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. **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;	required to receive training from the Agency Nurse. (Individual #2) **When DSP were asked who provided them training on diabetes as it relates to the Individual, the following was reported:** • DSP #547 stated, "SLP." According to Individual Specific Training Section of the ISP, DSP are required to receive training from the Agency Nurse. (Individual #2) **When DSP were asked who provided them training on the Individual's Seizure Disorder, the following was reported:** • DSP #547 stated, "SLP." As indicated by the Individual Specific Training section of the ISP. Day Support staff are required to receive training from the Agency Nurse. (Individual #2) **When DSP were asked if the Individual had any assistive devices and/or adaptive equipment and if it was on functioning order, the following was reported:** • DSP #547 stated, "No." Per Assistive Technology list the individual has hearing aids. (Individual #2)		

Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	Standard Level Deficiency		
NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 7 of 85 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Personnel (DSP):** • DSP #501 - Date of hire 7/31/2017, completed 8/2/2017. • DSP #544 - Date of hire 5/3/2016, completed 5/6/2016. • DSP #547 - Date of hire 3/17/2017, completed 6/12/2017. • DSP #559 - Date of hire 9/14/2016, completed 9/20/2016. • DSP #565 - Date of hire 11/15/2016, completed 11/17/2016. • DSP #568 - Date of hire 3/18/2016, completed 3/21/2016. • DSP #569 - Date of hire 5/31/2017, completed 6/7/2017.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

an inquiry to the registry concerning that 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. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. 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.			

Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency		
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** 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. **B. Training curriculum:** 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.	Based on record review and interview, the Agency did not ensure Incident Management Training for 8 of 85 Agency Personnel. **Direct Support Personnel (DSP)** Incident Management Training (Abuse, Neglect and Exploitation) (#547, 557, 568) **When Direct Support Personnel were asked what State Agency must be contacted when there is suspected Abuse, Neglect or Exploitation, the following was reported:** • DSP #513 stated, "I don't know, I can't remember." Staff was not able to identify the State Agency as Division of Health Improvement. • DSP #545 stated, "There's a 1-800 number you call, it's in MARs book." Staff was not able to identify the State Agency as Division of Health Improvement. • DSP #547 stated, "I would call my site lead to get number, it's a 1-800- number we call." Staff was not able to identify the State Agency as Division of Health Improvement. • DSP #549 stated, "There's a number for that." Staff was not able to identify the State Agency as Division of Health Improvement. • DSP #559 stated, "Call Adult Protective Services, my staff lead and 911." Staff was not able to identify the State Agency as Division of Health Improvement.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

C. Incident management system training curriculum requirements: **(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: **(a)** an overview of the potential risk of abuse, neglect, or exploitation; **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths; **(d)** specific instructions on how to respond to abuse, neglect, or exploitation; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. **(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule. **(3)** All new employees and volunteers shall receive training prior to providing services to consumers. **D. Training documentation:** All community-based service providers shall prepare training documentation for each employee and volunteer	**When DSP were asked to give an example of Exploitation, the following was reported:** • DSP #531 stated, "I would tell someone to do something that they would do to get them in trouble." Staff was not able to give an example of exploitation. (Individual #9)		

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 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. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.			

Tag # 1A36 Service Coordination Requirements	Standard Level Deficiency		
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: K. In addition to the applicable requirements described in policy statements B – I (above), direct support staff, direct support supervisors, and internal service coordinators shall complete DDSD-approved core curriculum training. Attachments A and B to this policy identify the specific competency requirements for the following levels of core curriculum training: 1. Introductory Level – must be completed within thirty (30) days of assignment to his/her position with the agency. 2. Orientation – must be completed within ninety (90) days of assignment to his/her position with the agency. 3. Level I – must be completed within one (1) year of assignment to his/her position with the agency. **NMAC 7.26.5.7** "service coordinator": the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency **NMAC 7.26.5.11** (b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the service	Based on record review, the Agency did not ensure that Orientation and Training requirements were met for 1 of 2 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: **Sexuality for People with Developmental Disabilities:** • Not Found (#525)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

coordinators shall assure the action plans and strategies are implemented consistent with the provisions of the ISP, and shall report to the case manager on ISP implementation and the individual's progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more "key" community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDTs selection are set forth as follows: (i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations; (ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations; (iii) the designated service coordinator shall be familiar with and understand community service delivery and supports; (iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;			

Tag # 1A43.1 General Events Reporting - Individual Approval	Standard Level Deficiency		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy: General Events Reporting Effective 1/1/2012 **1. Purpose** To report, track and analyze significant events experiences by adult participants of the DD Waiver program, which do not meet criteria for abuse, neglect or exploitation, or other "reportable incident" as defined by the Incident Management Bureau of the Division of Health Improvement, Department of Health, but which pose a risk to individuals served. Analysis of reported significant events is intended to identify emerging patterns so that preventative actions can be identified at the individual, provider agency, regional and statewide levels. **II. Policy Statements** A. Designated employees of each agency will enter specified information into the General Events Reporting section of the secure website operated under contract by Therap Services within 2 business days of the occurrence or knowledge by the reporting agency of any of the following defined events in which DDSD requires reporting: Chocking, Missing Person, Suicide Attempt or Threat, Restraint related to Behavior, Serious Injury including Skin Breakdown, Fall (with or without injury), Out of Home Placement and Infections…Providers shall utilize the "Significant Events Reporting System Guide" to assure that events are reported correctly for DDSD tracking purposes. At providers' discretion additional events may be tracked within the Therap General Events Reporting	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 6 of 9 individuals. **The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and approved within 2 business days:** Individual #1 • General Events Report (GER) indicates on 6/7/2017 the Individual had a self-injurious behavior (Injury). GER was approved on 6/12/2017. • General Events Report (GER) indicates on 9/7/2017 the Individual developed rash on chest and stomach (Injury). GER was approved on 9/20/2017. • General Events Report (GER) indicates on 9/29/2017 staff noticed the Individual had blood in urine (Injury). GER was approved on 10/4/2017. Individual #3 • General Events Report (GER) indicates on 11/30/2016 the Individual's stoma appeared swollen and was taken to the ER and admitted (Hospital). GER was approved on 12/5/2016. • General Events Report (GER) indicates on 5/28/2017 the Individual began to vomit, refused food and water, was taken to the ER and admitted (Hospital). GER was approved on 6/9/2017.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

which are not required by DDSD such as medication errors. B. General Events Reporting does not replace agency obligations to report abuse, neglect, exploitation and other reportable incidents in compliance with policies and procedures issued by the Department's Incident Management Bureau of the Division of Health Improvement.	• General Events Report (GER) indicates on 7/17/2017 the Individual was taken to the doctor to assess Ileostomy bag contents (Injury). GER was approved on 7/24/2017. • General Events Report (GER) indicates on 8/6/2017 the Individual was taken to the Urgent Care for Conjunctivitis (Hospital). GER was approved on 8/11/2017. • General Events Report (GER) indicates on 9/16/2017 the Individual was taken to the ER for Bowel Obstruction and admitted (Hospital). GER was approved on 9/28/2017. Individual #4 • General Events Report (GER) indicates on 1/5/2017 the Individual loss her balance and fell with small scratch on left knee (Injury). GER was approved on 1/11/2017. • General Events Report (GER) indicates on 8/10/2017 the Individual had injury to their nose and right leg (Injury). GER was approved on 8/21/2017. • General Events Report (GER) indicates on 9/27/2017 the Individual became anxious and felt uncomfortable was taken to ER for assessment and was sent home (Hospital). GER was approved on 10/3/2017. Individual #5 • General Events Report (GER) indicates on 11/23/2016 the Individual had redness from scratching left arm (Injury). GER was approved on 12/7/2016.		

	• General Events Report (GER) indicates on 5/20/2017 the Individual had a bloody nose (Injury). GER was approved on 5/25/2017. • General Events Report (GER) indicates on 5/21/2017 the Individual had redness on right hip and underarm from not being stable in Hoyer sling (Injury). GER was approved on 5/25/2017. • General Events Report (GER) indicates on 5/23/2017 the Individual had bruises from outpatient procedure visit (Other). GER was approved on 6/5/2017. Individual #8 • General Events Report (GER) indicates on 12/15/2016 the Individual became upset and started to pinch and twist her fingers (Injury). GER was approved on 12/21/2016. • General Events Report (GER) indicates on 2/6/2017 the Individual had bruises to her bottom and left leg due to previous incident (Injury). GER was approved on 2/10/2017. • General Events Report (GER) indicates on 2/23/2017 the Individual complained of pain to her left knee, nurse instructed staff to take Individual to Urgent Care for evaluation (Hospital). GER was approved on 3/7/2017. • General Events Report (GER) indicates on 3/20/2017 the Individual was assisted with PRN medication for agitation (PRN Psychotropic Use). GER was approved on 3/28/2017.		

	• General Events Report (GER) indicates on 4/14/2017 the Individual developed bruising on her bottom from SIB behavior from day before (Injury). GER was approved on 4/21/2017. • General Events Report (GER) indicates on 4/21/2017 the Individual showed signs of bruising on lower portion of back and bottom. An ANE report was filed for suspicious injury (Injury). GER was approved on 4/26/2017. • General Events Report (GER) indicates on 5/23/2017 staff discovered the Individual had developed bruises on left side of thigh and left ankle (Injury). GER was approved on 6/5/2017. • General Events Report (GER) indicates on 5/26/2017 the Individual had scratches on left shoulder and nail marks on right arm (Injury). GER was approved on 6/5/2017. • General Events Report (GER) indicates on 5/28/2017 the Individual had developed small bruises on right side of waist (Injury). GER was approved on 6/5/2017. • General Events Report (GER) indicates on 7/8/2017 the Individual had a bruise on right side of hip (Injury). GER was approved on 7/13/2017. Individual #9 • General Events Report (GER) indicates on 12/1/2016 the Individual did not respond to staff and had to be assured everything was alright. During the evening the Individual refused her medication and		

	engaged in self-injurious behavior (Injury). GER was approved on 12/7/2016. • General Events Report (GER) indicates on 12/2/2016 the Individual was taken to Urgent Care for bite on right hand she gave herself the night before for evaluation of wound (Hospital). GER was approved on 12/7/2016. • General Events Report (GER) indicates on 2/24/2017 the Individual was assisted with PRN medication for agitation with her roommate (PRN Psychotropic Use). GER was approved on 3/6/2017. • General Events Report (GER) indicates on 5/25/2017 the Individual hit her head after picking up her handkerchief (Accident with no injury). GER was approved on 6/5/2017. • General Events Report (GER) indicates on 5/26/2017 the Individual became upset, hit staff and was verbally abusive then started to hit her head and was taken to the ER for evaluation (Hospital). GER was approved on 6/5/2017. • General Events Report (GER) indicates on 5/28/2017 the Individual became emotional and was assisted with an PRN medication (PRN Psychotropic Use). GER was approved on 6/5/2017. • General Events Report (GER) indicates on 6/28/2017 the Individual became upset refused to eat her meal and eventually bit her left hand and scratched herself (Injury). GER was approved on 7/5/2017.		

	• General Events Report (GER) indicates on 7/8/2017 the Individual became upset with staff exhibited behaviors during the evening, was found on the floor, had fallen out of her bed (Fall without injury). GER was approved on 7/13/2017.		

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Health and Welfare **-** *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A03.1 CQI System - Implementation	**Standard Level Deficiency**		
STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS 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: i. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance; ii. The entities or individuals responsible for conducting the discovery/monitoring processes;	Based on record review, interview and observation, the Agency had not fully implemented their Continuous Quality Management System as required by standard. **Multiple Deficiencies Including CoPs** • Review of the findings identified during the on-site survey (October 16 – 19, 2017) 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.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

iii. The types of information used to measure performance; and, iv. The frequency with which performance is measured. **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **F. Quality assurance/quality improvement program for community-based service providers: F. Quality assurance/quality improvement program for community-based service providers:** The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program: **(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; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(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.			

Tag # 1A08.2 Healthcare Requirements	Standard Level Deficiency		
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012** **III. Requirement Amendments(s) or Clarifications:** 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. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **Chapter 5 (CIES) 3. Agency Requirements: H. Consumer Records Policy:** All Provider	Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 5 of 9 individuals receiving Community Inclusion, Living Services and Other Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Inclusion Services / Other Services Healthcare Requirements (Individuals Receiving Inclusion / Other Services Only):*** **Vision Exam** • Individual #6 - As indicated by collateral documentation reviewed, exam was completed on 8/18/2016. Follow-up was to be completed in 1 year. No evidence of follow-up found. ***Community Living Services / Community Inclusion Services (Individuals Receiving Multiple Services):*** **Dental Exam** • Individual #8 - As indicated by collateral documentation reviewed, exam was completed on 4/26/2017. Follow-up was to be completed on 7/12/2017. No evidence of follow-up found. **Vision Exam** • Individual #5 - As indicated by collateral documentation reviewed, exam was completed on 6/22/2016. Follow-up was to be completed in 1 year. No evidence of follow-up found.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy. **Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy:** 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. **Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy:** 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. **Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy:** 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. **Chapter 13 (IMLS) 2. Service Requirements:**	**Auditory Exam** • Individual #1 - As indicated by collateral documentation reviewed, exam was recommended on 8/16/2016. No evidence of exam results were found. • Individual #3 - As indicated by collateral documentation reviewed, exam was completed on 5/20/2014. Follow-up was to be completed in 1 year. No evidence of follow-up found. • Individual #5 - As indicated by collateral documentation reviewed, exam was completed on 9/1/2016. Follow-up was to be completed in 1 year. No evidence of follow-up found. **Colonoscopy** • Individual #3 - As indicated by collateral documentation reviewed, exam was recommended by Primary Care Physician on 9/7/2017. No evidence of exam results were found. **Review of Psychotropic Medication** • Individual #8 - As indicated by collateral documentation reviewed, exam was completed on 2/3/2017. Follow-up was to be completed in 3 months. No evidence of follow-up found.		

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)… Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY Requirements: D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP			

meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall 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. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life			

threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT. (5) That the physical property and grounds are free of hazards to the individual's health and safety. (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following: (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).			

Tag # 1A09 Medication Delivery - Routine Medication Administration	Standard Level Deficiency		
NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** - ***D. Administration of Drugs:*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: • symptoms that indicate the use of the medication, • exact dosage to be used, and	Medication Administration Records (MAR) were reviewed for the months of September and October 2017. Based on record review, 2 of 9 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #3 September 2017 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Famotidine 20mg tablet (1 time daily) – Blank 9/3 (8:00 PM) As indicated by Physician's Orders the individual is to take the following medication. Review of the Medication Administration Record found no evidence that medication is documented on the MAR. • Megestrol Acetate 40 mg (1 time daily) • Sodium Chloride 1 gram (2 times daily) Individual #8 September 2017 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Amlodipine Besylate 5mg tablet (1 time daily)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

• the exact amount to be used in a 24-hour period. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 5 (CIES) 1. Scope of Service B. Self Employment 8.** Providing assistance with medication delivery as outlined in the ISP; **C. Individual Community Integrated Employment 3.** Providing assistance with medication delivery as outlined in the ISP; **D. Group Community Integrated Employment 4.** Providing assistance with medication delivery as outlined in the ISP; and **B. Community Integrated Employment Agency Staffing Requirements: o.** Comply with DDSD Medication Assessment and Delivery Policy and Procedures; **CHAPTER 6 (CCS) 1. Scope of Services A. Individualized Customized Community Supports 19.** Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. **C. Small Group Customized Community Supports 19.** Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. **D. Group Customized Community Supports 19.** Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. **CHAPTER 11 (FL) 1 SCOPE OF SERVICES A. Living Supports- Family Living Services:** The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT):			

19. 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 **I. Healthcare Requirements for Family Living.** **3. B.** Adult Nursing Services for medication oversight are required for all surrogate Living 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. 6. 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. 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; b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: 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; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and 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. 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 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. 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. 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. 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. iii. If the substitute care provider is a surrogate (not related by affinity or consanguinity) Medication Oversight must be selected and provided. **CHAPTER 12 (SL) 2. Service Requirements K. Training and Requirements: 3.** 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. 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; b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: 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; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and 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.			

c. When PRN medications are used, there must be clear documentation that the DSP contacted the agency nurse prior to assisting with the medication. d. 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 e. 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 administrating the medication, signs, and symptoms of adverse events and interactions with other medications. **CHAPTER 13 (IMLS) 2. Service Requirements. B.** There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY Requirements: E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment			

and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (1) All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals shall be licensed by the Board of Pharmacy, per current regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.			

(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;			

Tag # 1A09.1 Medication Delivery - PRN Medication Administration	Standard Level Deficiency		
NMAC 16.19.11.8 MINIMUM STANDARDS: **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the	Medication Administration Records (MAR) were reviewed for the months of September and October 2017. Based on record review, 1 of 9 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #2 September 2017 As indicated by the Medication Administration Records the individual is to take Fish Oil Omega 3; 340 - 1,000mg (PRN). According to the Physician's Orders, Fish Oil Omega 3; 300 - 1,000mg is to be taken as needed Medication Administration Record and Physician's Orders do not match.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

administering of the medication. This shall include: • symptoms that indicate the use of the medication, • exact dosage to be used, and • the exact amount to be used in a 24-hour period. **Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the			

Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 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. 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. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:** **Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** 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). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.). Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) 1 SCOPE OF SERVICES** **A. Living Supports- Family Living Services:** The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT): **19.** 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			

I. Healthcare Requirements for Family Living. **3. 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. **6.** 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. 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; g. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: 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; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;			

iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and 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. 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 i. 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. 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. 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. v. 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. vi. If the substitute care provider is a surrogate (not related by affinity or consanguinity) Medication Oversight must be selected and provided. **CHAPTER 12 (SL) 2. Service Requirements K. Training and Requirements: 3.** 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.			

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; b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: 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; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and 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. 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			

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 administrating the medication, signs, and symptoms of adverse events and interactions with other medications. **CHAPTER 13 (IMLS) 2. Service Requirements. B.** There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY Requirements:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing			

Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;			

(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;			

Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 4 (CMgt) I. Case Management Services: 1. Scope of Services: S.** Maintain a complete record for the individual's DDW services, as specified in DDSD Consumer Records Requirements Policy; **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012** **III. Requirement Amendments(s) or Clarifications:** 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. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY Requirements:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 4 of 9 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Quarterly Nursing Review of HCP/Medical Emergency Response Plans:** • None found for 11/2016 – 4/2017 and 5/2017 – 7/2017 (Term of ISP 5/1/2016 - 4/30/2017 and 5/1/2017 - 4/30/2018) (#5) • None found for 10/2016 - 12/2016 (ISP Term 4/1/2016 - 3/31/2017) (#8) **Semi-Annual Nursing Review of HCP/Medical Emergency Response Plans:** • None found for 11/2016 - 1/2017 (Term of ISP 5/28/2016 - 5/27/2017) (ISP meeting held 2/16/2017) (#7) **Medical Emergency Response Plans:** • **Allergies** ◦ Individual #9 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses,			

allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.			

Tag # 1A27.3 Duty to Report IRs Filed During On-Site Survey	Standard Level Deficiency		
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **A. Duty to report:** **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** **(1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any	Based on record review, the Agency did not report suspected abuse, neglect, or exploitation, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 9 Individuals. During the on-site survey October 16 – 19, 2017, surveyors observed the following: **During the on-site visit Surveyor's observed the following:** • During a home visit on 10/18/2017, Surveyors were informed by DSP #547 of the individual kicking staff out of the home which left the individual without staff supervision for up to 8 hours. According to the ISP Health and Safety section, the individual "requires 24/7supports and 1:1 supervision during the majority of the day/night." As a result of what was observed the following incident was reported: Individual #2 • A State Incident Report of Neglect, was filed on 10/19/2017. Incident report was reported to DHI.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242 . Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242  . **(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be			

submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form. **(3) Limited provider investigation:** No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation. **(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall: **(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable; **(b)** be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and **(c)** Provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057. **(5) Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or			

exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident. **(6) Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative. **(7) Case manager or consultant notification by community-based service providers:** The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant. **(8) Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation			

Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency		
7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** 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. **E. Consumer and guardian orientation packet:** Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 1 of 9 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: **Parent/Guardian Acknowledgment (Abuse, Neglect and Exploitation):** • Not Current (#3)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

Tag # 1A29 Complaints / Grievances – Acknowledgement	Standard Level Deficiency		
NMAC 7.26.3.6 A These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process: A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure	Based on record review, the Agency did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 9 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: **Complaints / Grievances Acknowledgement** • Not Found (#1)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

Tag # 1A31 Client Rights/Human Rights	Standard Level Deficiency		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]	Based on record review, the Agency did not ensure the rights of Individuals was not restricted or limited for 1 of 9 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. No documentation was found regarding Human Rights Approval: • Physical Restraint (Buckle Buddy) - (Individual #4).	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

Long Term Services Division **Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003** **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans. Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies: • Aversive Intervention Prohibitions • Psychotropic Medications Use • Behavioral Support Service Provision. A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up. **A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS** Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval. 2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support			

Plans approved by the Human Rights Committee will be reviewed at least quarterly. 3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:** **Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** **B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).			

Tag # 1A33.1 Board of Pharmacy – License	Standard Level Deficiency		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **6. Display of License and Inspection Reports** A. The following are required to be publicly displayed: • Current Custodial Drug Permit from the NM Board of Pharmacy • Current registration from the consultant pharmacist • Current NM Board of Pharmacy Inspection Report	Based on observation, the Agency did not provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 3 of 7 residential and/or service sites where required: **Individual Residence** • Current Custodial Drug Permit from the NM Board of Pharmacy (#1, 3, 5, 8) *Note: The following Individuals share a residence:* ➢ #3, 8	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) Living Supports – Family Living Agency Requirements G. Residence Requirements for Living Supports- Family Living Services:** 1. Family Living Services providers must assure that each individual's residence is maintained to be clean, safe and comfortable and accommodates the individuals' daily living, social and leisure activities. In addition, the residence must: a. Maintain basic utilities, i.e., gas, power, water and telephone; 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; c. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system; d. Have a general-purpose first aid kit; e. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 3 of 7 Supported Living residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** Water temperature in home does not exceed safe temperature (110^0 F) • Water temperature in home measured 160^0 F (#2) Water temperature in home does not exceed safe temperature (110^0 F) • Water temperature in home measured 133^0 F (#3, 8) Water temperature in home does not exceed safe temperature (110^0 F) • Water temperature in home measured 138.6^0 F (#7) • General-purpose first aid kit (#3, 8) • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#2) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#2)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

f. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year; g. 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 h. 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. **CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports- Supported Living Services:** 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: a. Maintain basic utilities, i.e., gas, power, water, and telephone; 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;	• Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#2) *Note: The following Individuals share a residence:* ➢ #3, 8		

c. Ensure water temperature in home does not exceed safe temperature (110^0 F); d. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system; e. Have a general-purpose First Aid kit; f. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; 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; 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 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. **CHAPTER 13 (IMLS) 2. Service Requirements R. Staff Qualifications: 3. Supervisor Qualifications And Requirements:**			

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. 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. 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. 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.			

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Medicaid Billing/Reimbursement - *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 6 (CCS) 4. REIMBURSEMENT** **A. Required Records:** Customized Community Supports Services 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. Customized Community Supports Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations. B. Billable Unit: 1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit. 2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit. 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 assignment.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 1 of 6 individuals. Individual #4 September 2017 • The Agency billed 116 units of Customized Community Supports (group) (T2021 HB U7) from 9/1/17 through 9/30/2017. Documentation received accounted for 108 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)*	**Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

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. 5. The billable unit for Individual Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit. 6. The billable unit for Fiscal Management for Adult Education is one dollar per unit including a 10% administrative processing fee. 7. The billable units for Adult Nursing Services are addressed in the Adult Nursing Services Chapter. C. Billable Activities: All DSP activities that are: a. Provided face to face with the individual; b. Described in the individual's approved ISP; c. Provided in accordance with the Scope of Services; and d. Activities included in billable services, activities or situations. 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.			

Therapy Services, Behavioral Support Consultation (BSC), and Case Management may be provided and billed for the same hours, on the same dates of service as Customized Community Supports **NMAC 8.302.1.17 Effective Date 9-15-08 Record Keeping and Documentation Requirements -** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. **Detail Required in Records -** Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed, diagnosis and medical necessity of any service . . . Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient. **Services Billed by Units of Time -** Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit. **Records Retention -** A provider who receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:			

(1) treatment or care of any eligible recipient (2) services or goods provided to any eligible recipient (3) amounts paid by MAD on behalf of any eligible recipient; and (4) any records required by MAD for the administration of Medicaid.			

Tag # LS26 / 6L26 Supported Living Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 12 (SL) 4. REIMBURSEMENT:** **A.** Supported Living 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 Supported Living Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the Human Services Department Billing Regulations. a. The rate for Supported Living is based on categories associated with each individual's NM DDW Group; and b. A non-ambulatory stipend is available for those who meet assessed need requirements. B. Billable Units: 1. The billable unit for Supported Living is based on a daily rate. A day is considered 24 hours from midnight to midnight. If 12 or less hours of service are provided then one half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24 hour period. 2. The maximum allowable billable units cannot exceed three hundred forty (340) calendar days per ISP year or one hundred	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 3 of 8 individuals. Individual #1 July 2017 • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/19/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* Individual #2 July 2017 • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 7/1/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 7/2/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 7/3/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 7/4/2017. Documentation	**Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

seventy (170) calendar days per six (6) months. C. Billable Activities: 1. Billable activities shall include any activities which DSP provides in accordance with the Scope of Services for Living Supports which are not listed in non-billable services, activities, or situations below. **NMAC 8.302.1.17 Effective Date 9-15-08 Record Keeping and Documentation Requirements -** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. **Detail Required in Records -** Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed, diagnosis and medical necessity of any service . . . Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient. **Services Billed by Units of Time -** Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit. **Records Retention -** A provider who receives payment for treatment, services or goods must	received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 7/5/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 7/6/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* August 2017 • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 8/1/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 8/2/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 8/3/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)*		

retain all medical and business records relating to any of the following for a period of at least six years from the payment date: (1) treatment or care of any eligible recipient (2) services or goods provided to any eligible recipient (3) amounts paid by MAD on behalf of any eligible recipient; and (4) any records required by MAD for the administration of Medicaid. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:	• The Agency billed 1 unit of Supported Living (T2016 HB U4) on 8/4/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/5/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/6/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/7/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/8/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/9/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)*		

(1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT for community Living services** A. **Reimbursement** for Supported Living Services (1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year. (2) **Billable Activities** (a) Direct care provided to an individual in the residence any portion of the day. (b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community. (c) Any activities in which direct support staff provides in accordance with the Scope of Services. (3) Non-Billable Activities	• The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/10/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/11/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/12/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 U4) on 8/13/2017. No documentation was found on 8/13/2017 to justify the 1 unit billed. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/14/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/15/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)*		

(a) The Supported Living Services provider shall not bill DD Waiver for Room and Board. (b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services. (c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.	• The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/16/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/17/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/18/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/19/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/20/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/21/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-*		

	site survey. Provider please complete POC for ongoing QA/QI.) • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/22/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/23/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/24/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/25/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/26/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/27/2017. Documentation received accounted for .5		

	units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/28/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/29/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/30/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1unit of Supported Living (T2016 HB U4) on 8/31/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* September 2017 • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/1/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/2/2017.		

	Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/3/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/4/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/5/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/6/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/7/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/8/2017. Documentation		

	received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/9/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/10/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/11/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/12/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/13/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/14/2017.		

	Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/15/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/16/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/17/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/18/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/19/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/20/2017.		

	Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/21/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/22/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/23/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/24/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/25/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/26/2017.		

	Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/27/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/28/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/29/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 1 unit of Supported Living (T2016 HB U4) on 9/30/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* Individual #3 Septembers 2017 • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 9/29/2017. Documentation received accounted for .5 units. (*Note: Void/Adjust provided during on-*		

	site survey. Provider please complete POC for ongoing QA/QI.)		

Date: May 17, 2018

To: Eleanor Sanchez, Assistant Director
Provider: Progressive Residential Services of New Mexico, Inc.
Address: 1100 S. Main Street, Suite A
State/Zip: Las Cruces, New Mexico 88005

E-mail Address: esanchez@prs-nm.org

Region: Southwest Region
Survey Date: October 13 - 19, 2017
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2007:** Supported Living, Adult Habilitation
2012: Supported Living, Customized Community Supports, Customized In-Home Supports

Survey Type: Routine Survey

Dear Ms. Eleanor Sanchez;

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.18.2.DDW.D4244.3.RTN.09.18.137