Date:	August 13, 2019
To:	Michelle Bishop-Couch, Chief Executive Officer
Provider:	Cornucopia Adult and Family Services, Inc.
Address:	2002 Bridge Blvd. SW
City, State, Zip:	Albuquerque, New Mexico 87105
E-mail Address:	michelle@cornucopia-ads.org
Region:	Metro
Routine Survey:	September 7 - 13, 2018
Verification Survey:	July 12 – 19, 2019
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports
Survey Type:	Verification
Team Leader:	Wolf Krusemark, BFA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau
Team Member:	Monica Valdez, Healthcare Surveyor Advanced / Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau;

Dear Michelle Bishop-Couch;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on September 7 - 13, 2018.*

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

Compliance: This determination is based on your agency's compliance with Condition of Participation level and Standard level requirements. Deficiencies found only affect a small percentage of the Individuals on the survey sample *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

The following tags are identified as Standard Level:

- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*
- Tag # 1A43.1 General Events Reporting: Individual Reporting
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up

However, due to the new/repeat deficiencies your agency will be required to contact your DDSD Regional Office for technical assistance and follow up and complete the Plan of Correction document attached at the end of this report. Please respond to the Plan of Correction Coordinator within 10 business days of receipt of this letter.

Plan of Correction:
The attached Report of Findings identifies the new/repeat Standard Level deficiencies found during your agency's verification compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 10 business days from the receipt of this letter. The Plan of Correction must include the following:

1. Evidence your agency has contacted your DDSD Regional Office for technical assistance;
2. A Plan of Correction detailing Quality Assurance/Quality Improvement processes to prevent your agency from receiving deficiencies in the future. Please use the format provided at the end of this report;
3. Documentation verifying that newly cited deficiencies have been corrected.

Submission of your Plan of Correction:
Please submit your agency's Plan of Correction and documentation verifying correction of survey deficiencies within 10 business days of receipt of this letter to the parties below:

1. **Quality Management Bureau, Attention: Plan of Correction Coordinator**
   5301 Central Ave. NE Suite 400, New Mexico 87108

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

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

Please call the Plan of Correction Coordinator at 505-273-1930, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Wolf Krusemark, BFA

Wolf Krusemark, BFA
Team Lead/Healthcare Surveyor Supervisor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	July 12, 2019
Contact:	**Cornucopia Adult and Family Services, Inc.** Michelle Bishop-Couch, Chief Executive Officer **DOH/DHI/QMB** Wolf Krusemark, BFA, Team Lead/Healthcare Surveyor Supervisor
On-site Entrance Conference Date:	July 15, 2019
Present:	**Cornucopia Adult and Family Services, Inc.** Michelle Bishop-Couch, Chief Executive Officer Judy Manicki, Human Resources Director Veronica Dozal, Program Director Frances Barnes-Provencher, Finance Manager **DOH/DHI/QMB** Wolf Krusemark, BFA, Team Lead/Healthcare Surveyor Supervisor Monica Valdez, Healthcare Surveyor Advanced / Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau;
Exit Conference Date:	July 19, 2019
Present:	**Cornucopia Adult and Family Services, Inc.** Michelle Bishop-Couch, Chief Executive Officer Veronica Dozal, Program Director Marti Madrid, Quality Assurance **DOH/DHI/QMB** Wolf Krusemark, BFA, Team Lead/Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Monica Valdez, BS, Healthcare Surveyor Advanced / Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau;
Administrative Locations Visited	1
Total Sample Size	9 1 - *Jackson* Class Members 8 - Non-*Jackson* Class Members 1 - Supported Living 5 - Family Living 8 - Customized Community Supports
Persons Served Records Reviewed	9
Direct Support Personnel Interviewed during Routine Survey	10
Direct Support Personnel Records Reviewed	59 (One DSP also performed duties as a Service Coordinator)

Substitute Care/Respite Personnel Records Reviewed	15
Service Coordinator Records Reviewed	5 (One Service Coordinator also performed duties as a DSP)
Administrative Interviews during Routine Survey	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
NM Attorney General's Office

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 other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); 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 Assurance 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 during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. 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.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

Service Domains and CoPs for <u>Living Care Arrangements and Community Inclusion</u> are as follows:

<u>Service Domain: Service Plan: ISP Implementation -</u> *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.3 –** Administrative Case File: Individual Service Plan / ISP Components
- **1A32 –** Administrative Case File: Individual Service Plan Implementation
- **LS14 –** Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- **IS14 –** CCS / CIES Service Delivery Site Case File (ISP and Healthcare Requirements)

<u>Service Domain: Qualified Providers -</u> *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.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A20 -** Direct Support Personnel Training
- **1A22 -** Agency Personnel Competency
- **1A37 –** Individual Specific Training

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):

- **1A25.1 –** Caregiver Criminal History Screening
- **1A26.1 –** Consolidated On-line Registry Employee Abuse Registry

Service Domain: Health, Welfare and Safety - *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.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.2 –** Administrative Case File: Healthcare Requirements & Follow-up
- **1A09 –** Medication Delivery Routine Medication Administration
- **1A09.1 –** Medication Delivery PRN Medication Administration
- **1A15.2 –** Administrative Case File: Healthcare Documentation (Therap and Required Plans)

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):

- **1A05 –** General Requirements / Agency Policy and Procedure Requirements
- **1A07 –** Social Security Income (SSI) Payments
- **1A09.2 –** Medication Delivery Nurse Approval for PRN Medication
- **1A15 –** Healthcare Documentation - Nurse Availability
- **1A31 –** Client Rights/Human Rights
- **LS25.1 –** Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

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.

Attachment D

QMB Determinations of Compliance

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. 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*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

Partial-Compliance with Standard Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags* indicates that a provider is in compliance with all Condition of Participation Level deficiencies but is out of compliance with a certain percentage of Standard Level deficiencies. This partial-compliance, if not corrected, may result in a negative outcome or the potential for more than minimal harm to individuals' health and safety. There are two ways to receive a determination of Partial Compliance with Standard Level Tags:

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.

2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. 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.

Non-Compliance:

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. 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. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 17 or more Standard Level Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any tag.

2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Standard Level Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
CoP Level Tags:	0 CoP	0 CoP	0 CoP	0 CoP	1 to 5 CoPs	0 to 5 CoPs	6 or more CoPs
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
"Non-Compliance"						**17 or more** Standard Level Tags with **75 to 100%** of the Individuals in the sample cited in any tag.	**Any Amount** of Standard Level Tags and **6 or more** Conditions of Participation Level Tags.
"Partial Compliance with Standard Level tags and Condition of Participation Level Tags"					**Any Amount** of Standard Level Tags, plus **1 to 5** Conditions of Participation Level tags.		
"Partial Compliance with Standard Level tags"			**up to 16** Standard Level Tags with **75 to 100%** of the individuals in the sample cited in any tag.	**17 or more** Standard Level Tags with **50 to 74%** of the individuals in the sample cited any tag.			
"Compliance"	**Up to 16** Standard Level Tags with **0 to 74%** of the individuals in the sample cited in any tag.	**17 or more** Standard Level Tags with **0 to 49%** of the individuals in the sample cited in any tag.					

Agency: **Cornucopia Adult and Family Services, Inc. - Metro**
Program: Developmental Disabilities Waiver
Service: ***2012 & 2018:*** Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports
Survey Type: Verification
Routine Survey: **September 7 - 13, 2018**
Verification Survey: **July 12 – 19, 2019**

Standard of Care	Routine Survey Deficiencies September 7 – 13, 2018	Verification Survey New and Repeat Deficiencies July 12 – 19, 2019
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 # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)	**Standard Level Deficiency**	**Standard Level Deficiency**
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. 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	Based on administrative 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 outcomes and action plan for 8 of 15 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 #2 • According to the Live Outcome; Action Step for "...will choose/select an application to learn" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018. Individual #6	**New / Repeat Finding:** Based on administrative 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 outcomes and action plan for 3 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 #2 • According to the Live Outcome; Action Step for "...will utilize computer skills and or other technologies" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2019.

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 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] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 6: Individual Service Plan (ISP)** **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All	• According to the Live Outcome; Action Step for "...will choose which exercise videos from 2 options" is to be completed 2 times per weekly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2018. • According to the Live Outcome; Action Step for "...will exercise" is to be completed 2 times per weekly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2018 - 8/2018. **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • According to the Live Outcome; Action Step for "...will choose a meal from menu" is to be completed 1time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2018. • According to the Live Outcome; Action Step for "...will create a list of ingredients" is to be completed 1time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2018. Individual #5 • According to the Live Outcome; Action Step for "...learn to write and say his home address" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2018.	**Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #9 • According to the Live Outcome; Action Step for "with assistance as needed one laundry basket is taken downstairs, …will carry it to the laundry room and place it in the front washer" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2019. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #9 • According to the Work/Learn Outcome; Action Step for "Cornucopia will make arrangements for…to go shopping for different sensory items" is to be completed at least 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2019. • According to the Work/Learn Outcome; Action Step for "when given the choice of 3 different sensory items to purchase…will chose at least one" is to be completed at least 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2019. • According to the Work/Learn Outcome; Action Step for "with assistance as needed…will place the sensory item she purchased in her sensory box" is to be completed at least 2 times per month. Evidence found indicated it was not

DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 8. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 9. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices 10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 11. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 12. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 13. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.	• According to the Live Outcome; Action Step for "...create and review the safety guidelines for his alone time' is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2018. Individual #9 • According to the Live Outcome; Action Step for "Plate, cup and spoon will be put in the same place each time for...to access" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018. • According to the Live Outcome; Action Step for "FLP will continue to assist...as needed to pick up her plate and cup and place them on the placemat in the correct spot" is to be completed at least 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018. • According to the Live Outcome; Action Step for "With assistance as needed after set up and after she has completed the above...will pick up the spoon and put it on the photo placemat on the correct spot" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018. **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #9	being completed at the required frequency as indicated in the ISP for 6/2019. • According to the Work/Learn Outcome; Action Step for "when presented with her sensory box…will choose an item to have for the day" is to be completed at least 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2019. Individual #12 • According to the Work/Learn Outcome; Action Step for "… will submit the calendar of outings she has chosen to participate in during the month" is to be completed at least 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2019. • According to the Work/Learn Outcome; Action Step for "…will review the activity calendar with staff weekly" is to be completed at least 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2019.

14. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.	• According to the Work/Learn Outcome; Action Step for "The Agency will make arrangements for...to dance at a community location" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018. • According to the Work/Learn Outcome; Action Step for "With assistance as needed...will practice dancing with another individual per her tolerance" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #12 • According to the Work/Learn Outcome; Action Step for "...will submit the calendar of outings she has chosen to participate in during the month" 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 8/2018. • According to the Work/Learn Outcome; Action Step for "...will review the activity calendar with staff" 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 8/2018. • According to the Work/Learn Outcome; Action Step for "...will wait for and follow staff instructions for loading the van outings" 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 8/2018. Individual #14 • According to the Work/Learn Outcome; Action Step for "...will attend music and dance related outings" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2018. • According to the Work/Learn Outcome; Action Step for "...will do 5 reps of hand/arm movements in response to music" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2018 - 8/2018.	

Standard of Care	Routine Survey Deficiencies September 7 – 13, 2018	Verification Survey New and Repeat Deficiencies July 12 – 19, 2019
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 # 1A43.1 General Events Reporting - Individual Reporting	**Standard Level Deficiency**	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 19: Provider Reporting Requirements:** **19.2 General Events Reporting (GER):** The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows: 1. DD Waiver Provider Agencies approved to provide Customized In- Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use GER in the Therap system. 2. DD Waiver Provider Agencies referenced above are responsible for entering specified information into the GER section of the secure website operated under contract by Therap according to the GER Reporting Requirements in Appendix B GER Requirements. 3. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap.	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 3 of 15 individuals. **The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within 2 business days:** Individual #2 • General Events Report (GER) indicates on 8/10/2018 the Individual went to Urgent Care (Urgent Care). GER was approved on 8/17/2018. Individual #5 • General Events Report (GER) indicates on 10/5/2017 the Individual was injured. (Injury). GER was pending approval. • General Events Report (GER) indicates on 2/18/2018 the Individual fell (Fall). GER was approved on 2/23/2018. • General Events Report (GER) indicates on 3/20/2018 the Individual fell (Fall). GER was approved on 3/26/2018. • General Events Report (GER) indicates on 8/28/2018 the Individual was a passenger in a vehicle that was rear-ended (Emergency Services). GER was approved on 9/7/2018.	**New / Repeat Finding:** Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 2 of 9 individuals. **The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within 2 business days:** Individual #9 • General Events Report (GER) indicates on 5/23/2019 the Individual fell (Fall). GER was approved on 5/30/2019. • General Events Report (GER) indicates on 6/8/2019 the Individual was injured. (Injury). GER was approved on 6/17/2019. Individual #11 • General Events Report (GER) indicates on 1/28/2019 the Individual fell (Fall). GER was approved on 1/31/2019. • General Events Report (GER) indicates on 6/28/2019 the Individual required restraint. (Restraint). GER was approved on 7/5/2019.

4. GER does not replace a Provider Agency's obligations to report ANE or other reportable incidents as described in Chapter 18: Incident Management System. 5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities. **Appendix B GER Requirements**: DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting: 1. Effective immediately, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau. 2. No alternative methods for reporting are permitted. **The following events need to be reported in the Therap GER:** - Emergency Room/Urgent Care/Emergency Medical Services - Falls Without Injury - Injury (including Falls, Choking, Skin Breakdown and Infection) - Law Enforcement Use - Medication Errors - Medication Documentation Errors - Missing Person/Elopement - Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission - PRN Psychotropic Medication - Restraint Related to Behavior - Suicide Attempt or Threat Entry Guidance: Provider Agencies must complete the following sections of the GER with detailed	Individual #11 • General Events Report (GER) indicates on 3/27/2018 the Individual "lunged" at staff and the police were called (Law Enforcement). GER was approved on 3/30/2018.	

information: profile information, event information, other event information, general information, notification, actions taken or planned, and the review follow up comments section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.		

Standard of Care	Routine Survey Deficiencies September 7 – 13, 2018	Verification Survey New and Repeat Deficiencies July 12 – 19, 2019
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 # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Condition of Participation Level Deficiency**	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 3 Safeguards: 3.1.1 Decision Consultation Process (DCP):** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: 1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual	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 provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 8 of 15 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Inclusion Services (Individuals Receiving Inclusion Services Only):*** **Annual Physical:** • Not Found (#12) **Dental Exam:** • Individual #12 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. **Auditory Exam:** • Individual #16 - As indicated by collateral documentation reviewed, exam was completed on 11/7/2016. Follow-up were recommended for an Ear, Nose and Throat (ENT) Specialist and for the Audiologist after the ENT appointment. No evidence of follow-up found.	**Repeat Finding:** 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 1 of 9 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Inclusion Services (Individuals Receiving Inclusion Services Only):*** **Dental Exam:** • Individual #12 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.

Quality Review (IQR) or other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the	***Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):*** **Annual Physical:** • Not Current (#8) **Dental Exam:** • Individual #1 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. **Vision Exam:** • Individual #3 - As indicated by collateral documentation reviewed, exam was completed on 4/25/2016. Follow-up was to be completed in 12 months. No evidence of follow-up found. • Individual #9 - As indicated by collateral documentation reviewed, exam was completed on 2/27/2017. Follow-up was to be completed in 12 months. No evidence of follow-up found. **Auditory Exam:** • Individual #6 - As indicated by collateral documentation reviewed, exam was completed on 5/19/2017. Follow-up was to be completed on 5/25/2017. No evidence of follow-up found. • Individual #7 - As indicated by collateral documentation reviewed, exam was completed on 7/12/2017. Follow-up was to be completed in 12 months. No evidence of follow-up found. **Bone Density Exam:** • Individual #7 - As indicated by collateral documentation reviewed, exam was completed on 12/15/2017. Follow-up was to be completed in 6 months. No evidence of follow-up found.	

information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary	**Podiatry Exam:** • Individual #6 - As indicated by collateral documentation reviewed, exam was completed on 8/2/2017. Follow-up was to be completed in 4 months. No evidence of follow-up found.	

Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form. The Physician Consultation form contains a list of all current medications. **Chapter 10: Living Care Arrangements (LCA) Living Supports-Supported Living: 10.3.9.6.1 Monitoring and Supervision** 4. Ensure and document the following: a. The person has a Primary Care Practitioner. b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist. c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist. d. The person receives a hearing test as recommended by a licensed audiologist. e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist. 5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine). **10.3.10.1 Living Care Arrangements (LCA) Living Supports-IMLS:** **10.3.10.2 General Requirements:** 9 . Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and		

receives an annual physical examination, specialty medical care as needed, and annual dental checkup by a licensed dentist). **Chapter 13 Nursing Services: 13.2.3 General Requirements:** 1. Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information.		

Standard of Care	Routine Survey Deficiencies September 7 – 13, 2018	Verification Survey New and Repeat Deficiencies July 12 – 19, 2019
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 Administrative Case File (Other Required Documents)	**Standard Level Deficiency**	**Completed**
Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	**Standard Level Deficiency**	**Completed**
Tag # 1A08.3 Administrative Case File: Individual Service Plan/ISP Components	**Condition of Participation Level Deficiency**	**Completed**
Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	**Condition of Participation Level Deficiency**	**Completed**
Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)	**Standard Level Deficiency**	**Completed**
Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	**Standard Level Deficiency**	**Completed**
Tag # IS04 Community Life Engagement	**Standard Level Deficiency**	**Completed**
Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare requirements)	**Condition of Participation Level Deficiency**	**Completed**
Tag # LS14.1 Residential Service Delivery Site Case File (Other Required Documentation)	**Standard Level Deficiency**	**Completed**
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 # 1A20 Direct Support Personnel Training	**Standard Level Deficiency**	**Completed**
Tag # 1A22 Agency Personnel Competency	**Standard Level Deficiency**	**Completed**
Tag # 1A37 Individual Specific Training	**Condition of Participation Level Deficiency**	**Completed**
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 # 1A07 Social Security Income (SSI) Payments	**Condition of Participation Level Deficiency**	**Completed**
Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	**Standard Level Deficiency**	**Completed**

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	**Condition of Participation Level Deficiency**	**Completed**
Tag # 1A29 Complaints / Grievances – Acknowledgement	**Standard Level Deficiency**	**Completed**
Tag # LS06 Family Living Requirements	**Standard Level Deficiency**	**Completed**
Tag # LS25 Residential Health and Safety (Supported Living & Family Living)	**Standard Level Deficiency**	**Completed**
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 # 5I44 Adult Habilitation Reimbursement	**Standard Level Deficiency**	**Completed**
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**	**Completed**
Tag # LS26 Supported Living Reimbursement	**Standard Level Deficiency**	**Completed**
Tag # LS27 Family Living Reimbursement	**Standard Level Deficiency**	**Completed**

	Verification Survey Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Tag # 1A32.1 **Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)**	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # 1A43.1 **General Events Reporting - Individual Reporting**	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A08.2 **Administrative Case File: Healthcare Requirements & Follow-up**	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date: August 30, 2019

To: Michelle Bishop-Couch, Chief Executive Officer
Provider: Cornucopia Adult and Family Services, Inc.
Address: 2002 Bridge Blvd. SW
City, State, Zip: Albuquerque, New Mexico 87105

E-mail Address: michelle@cornucopia-ads.org

Region: Metro
Routine Survey: September 7 - 13, 2018
Verification Survey: July 12 – 19, 2019

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2018:*** Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports

Survey Type: Verification

Dear Michelle Bishop-Couch:

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,

Monica Valdez, BS

Monica Valdez, BS
Healthcare Surveyor Advanced/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.20.1.DDW.D3796.5.VER.09.19.242