

Date: October 17, 2019

To: Shanin Arp, Area Director
Provider: The Tunland Corporation
Address: 626 E. Main Street, Suite 1
State/Zip: Farmington, New Mexico 87401

E-mail Address: shanina@tunland.com

Region: Northwest
Routine Survey: October 19 – 25, 2018
Verification Survey: September 23 – 25, 2019

Program Surveyed: Developmental Disabilities Waiver

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

Survey Type: Verification

Team Leader: Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Kayla Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Arp;

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 October 19 – 25, 2018*.

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

Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags: This determination is based on noncompliance with one to five (1 – 5) Condition of Participation Level Tags (*refer to Attachment D for details*). The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 1A09 Medication Delivery Routine Medication Administration (*New / Repeat Findings*)
- Tag # 1A09.1 Medication Delivery PRN Medication Administration (*New / Repeat Findings*)
- Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication (*New / Repeat Findings*)

The following tags are identified as Standard Level:

- Tag # 1A08.1 Administrative and Residential Case File: Progress Notes (*New / Repeat Findings*)
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (*Not Completed at Frequency*) (*New / Repeat Findings*)
- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements (*New / Repeat Findings*)

DIVISION OF HEALTH IMPROVEMENT

5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
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QMB Report of Findings – The Tunland Corporation – Northwest – Sept 23 – 25, 2019

Survey Report #: Q.20.1.DDW.99421381.1.VER.01.19.290

- Tag # 1A43.1 General Events Reporting: Individual Reporting (*New / Repeat Findings*)
- Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living) (*Repeat Findings*)

However, due to the new/repeat deficiencies your agency will be referred to the Internal Review Committee (IRC). Your agency will also 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
MonicaE.Valdez@state.nm.us

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 Monica Valdez at 505-273-1930 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,

Lora Norby

Lora Norby
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date: September 23, 2019

Contact: **Tungland Corporation**
Shanin Arp, Area Director

DOH/DHI/QMB
Lora Norby, Team Lead/Healthcare Surveyor

On-site Entrance Conference Date: September 24, 2019

Present: **The Tungland Corporation**
Shanin Arp, Area Director
Samantha Imel, Family Living Manager

DOH/DHI/QMB
Lora Norby, Team Lead/Healthcare Surveyor
Kayla Benally, BSW, Healthcare Surveyor

Exit Conference Date: September 25, 2019

Present: **The Tungland Corporation**
Shanin Arp, Area Director
Samantha Imel, Family Living Manager
Rebecca Jones, RN

DOH/DHI/QMB
Lora Norby, Team Lead/Healthcare Surveyor
Kayla Benally, BSW, Healthcare Surveyor

Administrative Locations Visited: 1

Total Sample Size: 11

2 - *Jackson* Class Members
9 - *Non-Jackson* Class Members

4 - Supported Living
4 - Family Living
2 - Customized In-Home Supports
7 - Customized Community Supports
2 - Community Integrated Employment

Persons Served Records Reviewed 11

Direct Support Personnel Records Reviewed 57

Direct Support Personnel Interviewed during Routine Survey 14

Substitute Care/Respite Personnel Records Reviewed 7

Service Coordinator Records Reviewed 1

QMB Report of Findings – The Tungland Corporation – Northwest – September 23 – 25, 2019

Survey Report #: Q.20.1.DDW.99421381.1.VER.01.19.290

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 DDS 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 (DDS), 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 Living Care Arrangements and Community Inclusion are as follows:

Service Domain: Service Plan: ISP Implementation - 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)

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.

QMB Report of Findings – The Tunland Corporation – Northwest – September 23 – 25, 2019

Survey Report #: Q.20.1.DDW.99421381.1.VER.01.19.290

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 Coordination - Nurse Availability / Knowledge
- 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 Bureau Chief **within 10 business days** of receipt of the final Report of Findings (**Note: No extensions are granted for the IRF**).
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, Valerie V. Valdez at valerie.valdez@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.

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 total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level 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	
Total 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 COP	0 to 5 CoPs	6 or more COP
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
<i>“Non-Compliance”</i>						17 or more Total Tags with 75 to 100% of the Individuals in the sample cited in any CoP Level tag.	Any Amount of Standard Level Tags and 6 or more Conditions of Participation Level Tags.
<i>“Partial Compliance with Standard Level tags and Condition of Participation Level Tags”</i>					Any Amount Standard Level Tags, plus 1 to 5 Conditions of Participation Level tags.		
<i>“Partial Compliance with Standard Level tags”</i>			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.			
<i>“Compliance”</i>	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: The Tunland Corporation – Northwest Region
Program: Developmental Disabilities Waiver
Service: 2018: Supported Living, Family Living, Customized In-Home Support, Customized Community Supports and Community Integrated Employment
Survey Type: Verification
Routine Survey: October 19 – 25, 2018
Verification Survey: September 23 – 25, 2019

Standard of Care	Routine Survey Deficiencies October 19 – 25, 2018	Verification Survey New and Repeat Deficiencies September 23 – 25, 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 # 1A08.1 Administrative and Residential Case File: Progress Notes	Standard Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>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 information necessary.</p> <p>DD Waiver Provider Agencies are required to adhere to the following:</p> <ol style="list-style-type: none"> 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. 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. 	<p>Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 4 of 11 Individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found:</p> <p>Administrative Case File:</p> <p>Supported Living Individual Intensive Behavioral Services Notes/Daily Contact Logs:</p> <p>Individual #7 July 2018</p> <ul style="list-style-type: none"> Review of progress notes indicate separate progress notes were not kept for Individual Intensive Behavioral Support services for 7/1 – 31, 2018. <p>Individual #10 July 2018</p> <ul style="list-style-type: none"> Review of progress notes indicate separate progress notes were not kept for Individual Intensive Behavioral Support services for 7/1 – 31, 2018. 	<p>New / Repeat Finding:</p> <p>Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 1 of 11 Individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found:</p> <p>Administrative Case File:</p> <p>Family Living Progress Notes/Daily Contact Logs:</p> <p>Individual #8 July 2019</p> <ul style="list-style-type: none"> Review of daily progress indicate notes did not contain an adequate description of services provided. <ul style="list-style-type: none"> 7/2 From 12:00am – 11:59 pm. Summary of services stated: “Pack for Day Hab.” 7/25 From 12:00am – 11:59 pm. Summary of services stated: “Started Laundry.”

<p>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>August 2018</p> <ul style="list-style-type: none"> Review of progress notes indicate separate progress notes were not kept for Individual Intensive Behavioral Support services for 8/1 – 31, 2018. <p>September 2018</p> <ul style="list-style-type: none"> Review of progress notes indicate separate progress notes were not kept for Individual Intensive Behavioral Support services for 9/1 – 30, 2018. <p>Residential Case File:</p> <p>Family Living Progress Notes/Daily Contact Logs</p> <ul style="list-style-type: none"> Individual #8 - None found for 10/15 - 22, 2018. (Date of home visit: 10/23/2018) Individual #9 - None found for 10/1 - 23, 2018. (Date of home visit: 10/24/2018) 	<ul style="list-style-type: none"> 7/26 From 12:00am – 11:59pm. Summary of services stated: “Made list for Day Hab.” <p>August 2019</p> <ul style="list-style-type: none"> Review of daily progress indicate notes did not contain an adequate description of services provided. 8/4 From 12:00am – 11:59 pm. Summary of services stated: “Play Banjo.” 8/5 From 12:00am – 11:59 pm. Summary of services stated: “Pick up glasses.” 8/19 From 12:00am – 11:59 pm. Summary of services stated: “Getting excited for his birthday.”
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Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)	Standard Level Deficiency	Standard Level Deficiency
<p>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.</p> <p>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.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental</p>	<p>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 6 of 11 individuals.</p> <p>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #3</p> <ul style="list-style-type: none"> • According to the Live Outcome; Action Step for "Add photos to album," 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 8/2018 - 9/2018. • According to the Live Outcome; Action Step for "Choose and participate in activity," 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 - 9/2018. <p>Individual #7</p> <ul style="list-style-type: none"> • According to the Live Outcome; Action Step for "Try something and ... will show preference," 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. <p>Individual #10</p>	<p>New / Repeat Finding:</p> <p>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 11 individuals.</p> <p>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #3</p> <ul style="list-style-type: none"> • According to the Live Outcome; Action Step for "Take pictures on tablet," is to be completed 2 timed per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2019. • According to the Live Outcome; Action Step for "Insert to App with music," 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 7/2019. <p>Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #7</p> <ul style="list-style-type: none"> • According to the Work/Learn Outcome; Action Step for "Utilize sensory item," is to be completed 2 times per week. Evidence found indicated it was

<p>disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>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.</p> <p>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 information necessary. DD Waiver Provider Agencies are required to adhere to the following:</p> <ol style="list-style-type: none"> 1. Client records must contain all documents essential to the service being provided and essential 	<ul style="list-style-type: none"> • According to the Live Outcome; Action Step "With assistance will choose a meal," 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 7/2018. • According to the Live Outcome; Action Step "With assistance will create a menu with the meal he has chosen," 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 7/2018. <p>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #2</p> <ul style="list-style-type: none"> • According to the Live Outcome; Action Step for "Remove old photos and place in album," 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 7/218 and 8/2018. <p>Individual #8</p> <ul style="list-style-type: none"> • According to the Live Outcome; Action Step for "Plan and choose a snack," 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 Live Outcome; Action Step for "Shop for ingredients," 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. <p>Individual #11</p>	<p>not being completed at the required frequency as indicated in the ISP for 7/2019 – 8/2019.</p> <p>Individual #8</p> <ul style="list-style-type: none"> • According to the Work/Learn Outcome; Action Step for "Practice singing and banjo," 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 7/2019 – 8/2019.
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<p>to ensuring the health and safety of the person during the provision of the service.</p> <p>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.</p> <p>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> • According to the Live Outcome; Action Step for "Use checklist to practice cleaning the bathroom," 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. <p>Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #2</p> <ul style="list-style-type: none"> • According to the Work/Learn Outcome; Action Step for "Utilize sign of the quarter," 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. <p>Individual #7</p> <ul style="list-style-type: none"> • According to the Work/Learn Outcome; Action Step for "Attend activity and have staff take picture," 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 - 9/2018. • According to the Work/Learn Outcome; Action Step for "Develop photos and add to choice making system," 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 8/2018. • According to the Work/Learn Outcome; Action Step for "Use choice making system," 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 - 9/2018. 	
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Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	Standard Level Deficiency	Standard Level Deficiency
<p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>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 information necessary. DD Waiver Provider Agencies are required to adhere to the following:</p> <ol style="list-style-type: none"> 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 	<p>Based on record review, the Agency did not complete written status reports as required for 3 of 11 individuals receiving Living Care Arrangements and Community Inclusion.</p> <p>Supported Living Semi-Annual Reports:</p> <ul style="list-style-type: none"> • Individual #10 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 10/26/2017 - 12/12/2017; Date Completed: 12/12/2017; ISP meeting held on 11/13/2017). <p>Customized Community Supports Semi-Annual Reports</p> <ul style="list-style-type: none"> • Individual #8 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 4/2018 - 5/2018 Date Completed: 6/22/2018; ISP meeting held on 6/22/2018). <p>Community Integrated Employment Services Semi-Annual Reports</p> <ul style="list-style-type: none"> • Individual #8 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 4/2018 - 5/2018; Date Completed: 6/11/2018 ISP meeting held on 6/22/2018). <p>Nursing Semi-Annual / Quarterly Reports:</p> <ul style="list-style-type: none"> • Individual #7 - None found for 10/2017 - 4/2018 and 4/2018 - 6/2018 (Term of ISP 10/14/2017 - 10/13/2018. ISP meeting held on 6/29/2018). 	<p>New / Repeat Finding:</p> <p>Based on record review, the Agency did not complete written status reports as required for 1 of 11 individuals receiving Living Care Arrangements and Community Inclusion.</p> <p>Supported Living Semi-Annual Reports:</p> <ul style="list-style-type: none"> • Individual #10 - Report not completed 14 days prior to the Annual ISP meeting. (<i>Term of ISP 3/6/2018 – 3/5/2019. Semi-Annual Report 9/6/2018 – 3/6/2019; Date Completed: 3/4/2019; ISP meeting held on 11/13/2018.</i>)

<p>electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable.</p> <p>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Chapter 19: Provider Reporting Requirements 19.5 Semi-Annual Reporting: The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDSD for QA activities. Semi-annual reports are required as follows:</p> <ol style="list-style-type: none"> 1. DD Waiver Provider Agencies, except AT, EMSP, Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports. 		
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<p>2. A Respite Provider Agency must submit a semi-annual progress report to the CM that describes progress on the Action Plan(s) and Desired Outcome(s) when Respite is the only service included in the ISP other than Case Management, for an adult age 21 or older.</p> <p>3. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days).</p> <p>4. The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting.</p> <p>5. Semi-annual reports must contain at a minimum written documentation of:</p> <ol style="list-style-type: none"> a. the name of the person and date on each page; b. the timeframe that the report covers; c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering; d. a description of progress towards Desired Outcomes in the ISP related to the service provided; e. a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing); f. significant changes in routine or staffing if applicable; g. unusual or significant life events, including significant change of health or behavioral health condition; h. the signature of the agency staff responsible for preparing the report; and i. any other required elements by service type that are detailed in these standards. 		
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Standard of Care	Routine Survey Deficiencies October 19 – 25, 2018	Verification Survey New and Repeat Deficiencies September 23 – 25, 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
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>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:</p> <ol style="list-style-type: none"> 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. 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. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap. GER does not replace a Provider Agency's 	<p>Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 6 of 11 individuals.</p> <p>The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within the required timeframe:</p> <p>Individual #2</p> <ul style="list-style-type: none"> General Events Report (GER) indicates on 12/29/2017 the Individual fell and was transported to the emergency room (Hospital). GER was approved on 1/4/2018. <p>Individual #3</p> <ul style="list-style-type: none"> General Events Report (GER) indicates on 11/2/2017 the Individual lost her balance and fell (Fall without Injury). GER was approved on 11/7/2017. General Events Report (GER) indicates on 11/29/2017 the Individual lost her balance and fell (Fall without Injury). GER was approved on 12/6/2017. General Events Report (GER) indicates on 12/5/2017 the Individual was taken to urgent care (Hospital). GER was approved on 12/11/2017. General Events Report (GER) indicates on 12/8/2017 the Individual slipped and fell on the 	<p>New / Repeat Finding:</p> <p>Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 7 of 11 individuals.</p> <p>The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within 2 business days and / or entered within 30 days for medication errors:</p> <p>Individual #2</p> <ul style="list-style-type: none"> General Events Report (GER) indicates on 2/20/2019 the Individual was shaking and was transported to the Urgent Care for evaluation (ER/Urgent Care). GER was approved on 2/25/2019. <p>Individual #3</p> <ul style="list-style-type: none"> General Events Report (GER) indicates on 3/4/2019 the Individual was taken to the Emergency room for evaluation of illness (ER/Urgent Care). GER was approved on 3/7/2019. General Events Report (GER) indicates on 3/1/2019 the Individual fell (Fall without Injury). GER was approved on 3/6/2019. <p>Individual #5</p> <ul style="list-style-type: none"> General Events Report (GER) indicates on 1/8/2019 the Individual was taken to Urgent Care Emergency room for evaluation of illness

<p>obligations to report ANE or other reportable incidents as described in Chapter 18: Incident Management System.</p> <p>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.</p> <p>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:</p> <p>1. <i>Effective immediately</i>, 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.</p> <p>2. No alternative methods for reporting are permitted.</p> <p><u>The following events need to be reported in the Therap GER:</u></p> <ul style="list-style-type: none"> • 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 	<p>bathroom rug (Fall without Injury). GER was approved on 12/12/2017.</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 8/7/2018 the Individual fell while trying to get her glasses off the table (Fall without Injury). GER was approved on 8/15/2018. • General Events Report (GER) indicates on 9/30/2018 the Individual lost her balance and was assisted to the ground (Fall without Injury). GER was approved on 10/3/2018. <p>Individual #5</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 1/29/2018 the Individual was taken to urgent care (Hospital). GER was approved on 2/1/2018. <p>Individual #7</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 3/18/2018 the Individual had a behavior and was given PRN Valium (PRN Psychotropic Use). GER was approved on 3/22/2018. <p>Individual #10</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 2/10/2018 the Individual was taken to urgent care and given PRN Ativan prior to being taken (Hospital / PRN Psychotropic Use). GER was approved on 2/15/2018. • General Events Report (GER) indicates on 6/18/2018 the police were called on the Individual for suspicious behavior near a playground (Law Enforcement Involvement). GER was approved on 6/21/2018. • General Events Report (GER) indicates on 8/21/20218 the Individual was taken to urgent 	<p>(ER/Urgent Care). GER was approved on 1/14/2019.</p> <p>Individual #7</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 5/23/2019 the Individual was given a PRN Psychotropic Medication for agitation (PRN Psychotropic Medication). GER was approved on 5/28/2019. • General Events Report (GER) indicates on 2/8/2019 the Individual was given a PRN Psychotropic Medication for agitation (PRN Psychotropic Medication). GER was approved on 2/13/2019. • General Events Report (GER) indicates on 2/3/2019 the Individual was given a PRN Psychotropic Medication for agitation (PRN Psychotropic Medication). GER was approved on 2/7/2019. • General Events Report (GER) indicates on 2/2/2019 the Individual was given a PRN Psychotropic Medication for agitation (PRN Psychotropic Medication). GER was approved on 2/7/2019. <p>Individual #9</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 7/1/2019 the Individual was taken to Urgent Care for illness (ER/Urgent Care). GER was approved on 7/5/2019. <p>Individual #10</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 1/2/2019 the Individual was taken to Urgent Care for illness (ER/Urgent Care). GER was approved on 1/9/2019.
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<p>Entry Guidance: Provider Agencies must complete the following sections of the GER with detailed 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. <u>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.</u></p>	<p>care (Hospital). GER was approved on 8/27/2018.</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 8/27/2018 the Individual became agitated. He was given PRN Ativan but continued to escalate. Law enforcement was called and the individual was transported to the ER and admitted (PRN Psychotropic Use, Law Enforcement Involvement, Hospital). GER was approved on 8/31/2018. <p>Individual #11</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 11/14/2017 the Individual was taken to the emergency room (Hospital). GER was approved on 11/28/2017. • General Events Report (GER) indicates on 3/15/2018 the Individual was taken to urgent care (Hospital). GER was approved on 3/22/2018. • General Events Report (GER) indicates on 7/24/2018 the Individual was taken to urgent care (Hospital). GER was approved on 7/30/2018. • General Events Report (GER) indicates on 8/22/2018 the Individual was taken to the emergency room by ambulance (Hospital). GER was approved on 8/27/2018 	<ul style="list-style-type: none"> • General Events Report (GER) indicates on 12/20/2018 the Individual was given a PRN Psychotropic Medication for agitation (PRN Psychotropic Medication). GER was approved on 12/31/2018. • General Events Report (GER) indicates on 12/17/2018 the Individual was given a PRN Psychotropic Medication for agitation (PRN Psychotropic Medication). GER was approved on 12/26/2018. • General Events Report (GER) indicates on 11/27/2018 the Individual was given a PRN Psychotropic Medication for agitation (PRN Psychotropic Medication). GER was approved on 12/3/2018. • General Events Report (GER) indicates on 11/14/2018 the Individual was given a PRN Psychotropic Medication for agitation (PRN Psychotropic Medication). GER was approved on 11/19/2018. <p>Individual #11</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 7/29/2019 the Individual had stomach and was taken to the Emergency room for evaluation (ER/Urgent Care). GER was approved on 8/1/2019.
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Standard of Care	Routine Survey Deficiencies October 19 – 25, 2018	Verification Survey New and Repeat Deficiencies September 23 – 25, 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 # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency	Condition of Participation Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR): A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for:</p> <ol style="list-style-type: none"> 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: <ol style="list-style-type: none"> a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times 	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Medication Administration Records (MAR) were reviewed for the months of September and October 2018.</p> <p>Based on record review, 3 of 11 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</p> <p>Individual #3 October 2018 As indicated by Physician's Orders, the individual is to take Calcium 600mg + Vitamin D 200 units (1 time daily). Medication in the medication box being given to the Individual was Calcium 600mg + Vitamin D 400 units (1 time daily). Physician's Orders and Medication do not match.</p> <p>Individual #5 October 2018 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Melatonin ER 3 mg (1 time daily) - Blank 10/22 (8:00 pm) • Prilosec 20 mg (2 times daily) - Blank 10/22 (8:00 pm) 	<p>New / Repeat Finding:</p> <p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Medication Administration Records (MAR) were reviewed for the months of July and August 2019.</p> <p>Based on record review, 2 of 11 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</p> <p>Individual #2 July 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Clotrimazole Cream 1% (1 time daily) - Blank 7/30, 7/31 (8:00 pm) <p>Individual #7 August 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Colace 100 mg (3 times daily) - Blank 8/9 (12:00 pm)

<p>and dates of administration for all ordered routine or PRN prescriptions or treatments; over the counter (OTC) or “comfort” medications or treatments and all self-selected herbal or vitamin therapy;</p> <p>c. Documentation of all time limited or discontinued medications or treatments;</p> <p>d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials;</p> <p>e. Documentation of refused, missed, or held medications or treatments;</p> <p>f. Documentation of any allergic reaction that occurred due to medication or treatments; and</p> <p>g. For PRN medications or treatments:</p> <p>i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period;</p> <p>ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and</p> <p>iii. documentation of the effectiveness of the PRN medication or treatment.</p> <p>Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery: Living Supports Provider Agencies must support and comply with:</p> <p>1. the processes identified in the DDS AWMD training;</p>	<ul style="list-style-type: none"> • Tylenol 500 mg (2 times daily) - Blank 10/22 (8:00 pm) • Depakote 125 mg (2 times daily) - Blank 10/22 (8:00 pm) • Zocor 40mg (1 time daily) - Blank 10/22 (8:00 pm) • Debrox 6.5% Ear Wax Drops (2 times weekly) (Mon & Tue) - Blank 10/22 (8:00 pm) <p>Individual #10 September 2018 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Intuniv (Guanfacine) 2mg (1 time daily) - Blank 9/23 (10:00 PM) 	
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- 2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services;
- 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and
- 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).

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
- the exact amount to be used in a 24-hour period.

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency	Condition of Participation Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR): A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP.</p> <p>Primary and Secondary Provider Agencies are responsible for:</p> <ol style="list-style-type: none"> 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. <ol style="list-style-type: none"> 7. Including the following on the MAR: <ol style="list-style-type: none"> a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; d. The initials of the individual administering or 	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Medication Administration Records (MAR) were reviewed for the months of September and October 2018.</p> <p>Based on record review, 2 of 11 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:</p> <p>Individual #5 October 2018 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Gas-X 125 mg – PRN - 10/17 (given 2 times)</p> <p>Individual #7 September 2018 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Milk of Magnesia - PRN - 9/27 (given 1 time) • Hydroxyzine HCL 50mg - PRN - 9/27, 29 & 30 (given 1 time)</p>	<p>New / Repeat Finding:</p> <p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Medication Administration Records (MAR) were reviewed for the months of July and August 2019.</p> <p>Based on record review, 2 of 11 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:</p> <p>Individual #7 July 2019 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Neurontin / Gabapentin 300 mg - PRN – 7/16 (given 1 time)</p> <p>Individual #10 July 2019 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Ativan/Lorazepam 1 mg - PRN – 7/8 (given 1 time)</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ativan/Lorazepam 1 mg - PRN – 7/8 (given 1 time)</p> <p>No Time of Administration was noted on the Medication Administration Record for the following PRN medication:</p>

<p>assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials;</p> <ul style="list-style-type: none"> e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: <ul style="list-style-type: none"> i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. <p>Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery: Living Supports Provider Agencies must support and comply with:</p> <ol style="list-style-type: none"> 1. the processes identified in the DDS AWMD training; 2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR). 		<ul style="list-style-type: none"> • Ativan/Lorazepam 1 mg - PRN – 7/8 (given 1 time)
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Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	Condition of Participation Level Deficiency	Condition of Participation Level
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 13 Nursing Services: 13.2.12 Medication Delivery: Nurses are required to:</p> <ol style="list-style-type: none"> 1. Be aware of the New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations. 2. Communicate with the Primary Care Practitioner and relevant specialists regarding medications and any concerns with medications or side effects. 3. Educate the person, guardian, family, and IDT regarding the use and implications of medications as needed. 4. Administer medications when required, such as intravenous medications; other specific injections; via NG tube; non-premixed nebulizer treatments or new prescriptions that have an ordered assessment. 5. Monitor the MAR or treatment records at least monthly for accuracy, PRN use and errors. 6. Respond to calls requesting delivery of PRNs from AWMD trained DSP and non-related (surrogate or host) Family Living Provider Agencies. 7. Assure that orders for PRN medications or treatments have: <ol style="list-style-type: none"> a. clear instructions for use; b. observable signs/symptoms or circumstances in which the medication is to be used or withheld; and c. documentation of the response to and effectiveness of the PRN medication administered. 8. Monitor the person's response to the use of routine or PRN pain medication and contact the prescriber as needed regarding its effectiveness. 9. Assure clear documentation when PRN medications are used, to include: <ol style="list-style-type: none"> a. DSP contact with nurse prior to assisting 	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not maintain documentation of PRN authorization as required by standard for 1 of 11 Individuals.</p> <p>Individual #7 September 2018 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: •Hydroxyzine HCL 50mg - PRN - 9/27 (given 1 time)</p>	<p>New / Repeat Finding:</p> <p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not maintain documentation of PRN authorization as required by standard for 2 of 11 Individuals.</p> <p>Individual #7 July 2019 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: •Neurontin / Gabapentin 300 mg - PRN – 7/16 (given 1 time)</p> <p>Individual #10 July 2019 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: •Ativan / Lorazepam 1 mg - PRN – 7/8 (given 1 time)</p>

<p>with medication.</p> <p>i. The only exception to prior consultation with the agency nurse is to administer selected emergency medications as listed on the Publications section of the DOH-DDSD - Clinical Services Website https://nmhealth.org/about/ddsd/pgsv/clinical/.</p> <p>b. Nursing instructions for use of the medication.</p> <p>c. Nursing follow-up on the results of the PRN use.</p> <p>d. When the nurse administers the PRN medication, the reasons why the medications were given and the person's response to the medication.</p>		
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Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	Standard Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 10: Living Care Arrangements (LCA) 10.3.6 Requirements for Each Residence: Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence:</p> <ol style="list-style-type: none"> 1. has basic utilities, i.e., gas, power, water, and telephone; 2. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher; 3. has a general-purpose first aid kit; 4. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift; 5. has water temperature that does not exceed a safe temperature (110⁰ F); 6. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP; 7. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy; 8. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 9. supports environmental modifications and assistive technology devices, 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 	<p>Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 3 of 7 Living Care Arrangement residences.</p> <p>Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:</p> <p>Family Living Requirements:</p> <ul style="list-style-type: none"> • Carbon monoxide detectors (#2, 3) • General-purpose first aid kit (#2) • Emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#3) • Emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy (#2, 8) 	<p>Repeat Finding:</p> <p>Based on record review, the Agency did not ensure that each individuals' residence met all requirements within the standard for 2 of 7 Living Care Arrangement residences.</p> <ul style="list-style-type: none"> • Per the Agency's approved Plan of Correction (POC), "Quality Assurance Residential Checks form was updated to now include check for all emergency equipment such as carbon monoxide detectors, first aid kits and emergency evacuation procedures. Quality Assurance Residential Checks to be completed by Quality Assurance Coordinator monthly at each Supported Living Residence. Family Living Manager to check for all emergency equipment during monthly home visits." • When the agency was asked to provide evidence of the "Quality Assurance Residential Check," #566 was unable to provide evidence of the Plan of Correction (POC) implementation for the following: <p>Family Living Requirements:</p> <ul style="list-style-type: none"> • Carbon monoxide detectors (#2) • General-purpose first aid kit (#2) • Emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy (#2, 8)

with the IDT;

10. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed;
11. has the phone number for poison control within line of site of the telephone;
12. has general household appliances, and kitchen and dining utensils;
13. has proper food storage and cleaning supplies;
14. has adequate food for three meals a day and individual preferences; and
15. has at least two bathrooms for residences with more than two residents.

Standard of Care	Routine Survey Deficiencies October 19 – 25, 2018	Verification Survey New and Repeat Deficiencies September 23 – 25, 2019
<i>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.</i>		
Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)	Standard Level Deficiency	COMPLETE
Tag # IS04 Community Life Engagement	Standard Level Deficiency	COMPLETE
Tag # IS12 Person Centered Assessment (Community Inclusion)	Standard Level Deficiency	COMPLETE
Tag # LS14 Residential Case File (ISP and Healthcare Requirements)	Standard Level Deficiency	COMPLETE
Tag # LS14.1 Residential Service Delivery Site Case File (Other Required Documentation)	Standard Level Deficiency	COMPLETE
<i>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.</i>		
Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency	COMPLETE
Tag # 1A22 Agency Personnel Competency	Standard Level Deficiency	COMPLETE
Tag #1A25 Caregiver Criminal History Screening	Standard Level Deficiency	COMPLETE
Tag # 1A25.1 Caregiver Criminal History Screening	Standard Level Deficiency	COMPLETE
Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	Standard Level Deficiency	COMPLETE
Tag # 1A26.1 Consolidated On-line Registry Employee Abuse Registry	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A37 Individual Specific Training	Standard Level Deficiency	COMPLETE
<i>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.</i>		

Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A09.0 Medication Delivery Routine Medication Administration	Standard Level Deficiency	COMPLETE
Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	Standard Level Deficiency	COMPLETE
Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Standard Level Deficiency	COMPLETE
Tag # 1A33 Board of Pharmacy: Med. Storage	Standard Level Deficiency	COMPLETE

Date: November 19, 2019

To: Shanin Arp, Area Director
Provider: The Tunland Corporation
Address: 626 E. Main Street, Suite 1
State/Zip: Farmington, New Mexico 87401

E-mail Address: shanina@tunland.com

Region: Northwest
Routine Survey: October 19 – 25, 2018
Verification Survey: September 23 – 25, 2019

Program Surveyed: Developmental Disabilities Waiver

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

Survey Type: Verification

Dear Ms. Arp:

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.99421381.1.VER.09.19.323

QMB Report of Findings – The Tunland Corporation – Northwest – Sept 23 – 25, 2019

Survey Report #: Q.20.1.DDW.99421381.1.VER.01.19.290