Date:	October 29, 2020
To:	Glen Carlberg, Executive Director
Provider:	Collins Lake Center (Collins Lake Autism Center)
Address:	254 Encinal Road
State/Zip:	Cleveland, New Mexico 87715
E-mail Address:	glen.carlberg.cl@gmail.com
Region:	Northeast
Routine Survey:	January 31 – February 5 and February 17 - 21, 2020 *(Note: Survey extended due to inclement weather)*
Verification Survey:	September 29 – October 23, 2020
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Family Living, Customized Community Supports
Survey Type:	Verification
Team Leader:	Wolf Krusemark, BFA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau
Team Members:	Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Kayla R. Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Glen Carlberg;

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 January 31 – February 5 and February 17 – 21, 2020.*

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)**

The following tags are identified as Standard Level:

- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements **(New / Repeat Findings)**

- Tag # 1A37 Individual Specific Training **(Repeat Findings)**
- Tag # 1A09.1.0 Medication Delivery PRN Medication Administration **(New Findings)**
- Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living) **(Repeat Findings)**

However, due to the new/repeat deficiencies your agency may 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 contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@state.nm.us 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,

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:	September 29, 2020
Contact:	**Collins Lake Center (Collins Lake Autism Center)** Glen Carlberg, Executive Director **DOH/DHI/QMB** Wolf Krusemark, BFA, Team Lead/Healthcare Surveyor Supervisor
On-site Entrance Conference Date:	September 29, 2020
Present:	**Collins Lake Center (Collins Lake Autism Center)** Glen Carlberg, Executive Director **DOH/DHI/QMB** Wolf Krusemark, BFA, Team Lead/Healthcare Surveyor Supervisor
Exit Conference Date:	October 23, 2020
Present:	**Collins Lake Center (Collins Lake Autism Center)** Glen Carlberg, Executive Director Marcella Martinez, Operations Manager **DOH/DHI/QMB** Wolf Krusemark, BFA, Team Lead/Healthcare Surveyor Supervisor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor **DDSD - Northeast Regional Office** Angela Pacheco, Regional Manager
Administrative Locations Visited:	0 *(Note: No administrative locations visited due to COVID – 19 Public Health Emergency)*
Total Sample Size:	3 0 - *Jackson* Class Members 3 - Non-*Jackson* Class Members 2 - Supported Living 1 - Family Living 3 - Customized Community Supports
Persons Served Records Reviewed	3
Direct Support Personnel Interviewed during Routine Survey	5
Direct Support Personnel Records Reviewed	12 *(One DSP also performs dual roles as Service Coordinator)*
Service Coordinator Records Reviewed	1 *(One Service Coordinator performs dual roles as a DSP)*
Nurse Interview completes during Routine Survey	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided

- 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

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 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.

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 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%	
"Non-Compliance"						**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.
"Partial Compliance with Standard Level tags and Condition of Participation Level Tags"					**Any Amount** 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: **Collins Lake Center (Collins Lake Autism Center) - Northeast Region**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Supported Living, Family Living, Customized Community Supports
Survey Type: Verification
Routine Survey: **January 31 – February 5 and February 17 - 21, 2020** *(Note: Survey extended due to inclement weather)*
Verification Survey: **September 29 – October 23, 2020**

Standard of Care	Routine Survey Deficiencies January 31 – February 5 and February 17 - 21, 2020	Verification Survey New and Repeat Deficiencies September 29 – October 23, 2020
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 # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements ***(Routine Survey - Upheld by IRF)***	**Standard Level Deficiency**	**Standard Level Deficiency**
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create	Based on record review, the Agency did not complete written status reports as required for 4 of 6 individuals receiving Living Care Arrangements and Community Inclusion. **Supported Living Semi-Annual Reports:** • Individual #6 – None found for 6/2019 – 8/2019. *(Term of ISP 12/1/2018 – 11/30/2019. ISP meeting held on 9/3/2019).* **Family Living Semi- Annual Reports:** • Individual #5 - None found for 8/2018 – 1/2019 and 1/2019 – 4/2019. *(Term of ISP 8/1/2018 – 7/31/2019. ISP meeting held on 5/5/2019).* **Customized Community Supports Semi-Annual Reports** • Individual #5 - None found for 8/2018 – 1/2019 and 1/2019 – 4/2019. *(Term of ISP 8/1/2018 – 7/31/2019. ISP meeting held on 5/5/2019).* • Individual #6 – None found for 6/2019 – 8/2019. *(Term of ISP 12/1/2018 – 11/30/2019. ISP meeting held on 9/3/2019).*	**New / Repeat Finding:** Based on record review, the Agency did not complete written status reports as required for 1 of 3 individuals receiving Living Care Arrangements and Community Inclusion. **Nursing Semi-Annual:** • Individual #2 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 6/2019 – 5/2020. Semi-Annual Report 11/25/2019 – 5/29/2020; Date Completed: 10/21/2020; ISP meeting held on 3/17/2020).*

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: 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	**Nursing Semi-Annual:** • Individual #2 – None found for 12/2018 – 2/2019. *(Term of ISP 6/1/2018 – 5/31/2019. ISP meeting held on 3/5/2019)* and 6/2019 – 7/2019. Report covered 7/25/2019 – 12/17/2019. *(Term of ISP 6/1/2019 – 5/31/2020). (Per regulations reports must coincide with ISP term.* • Individual #3 – None found for 4/2019 – 5/2019. Report covered 12/2018 – 3/2019. *(Term of ISP 12/1/2018 – 11/30/2019). (Per regulations reports must coincide with ISP term).* • Individual #6 – None found for 12/2018 – 5/2019 *(Term of ISP 12/1/2018 – 11/30/2019).* *(Note: Findings for Individuals #1, 5, 6 were upheld by IRF, other findings were not disputed).*	

upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **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: 1. DD Waiver Provider Agencies, except AT, EMSP, Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports. 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. 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). 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. 5. Semi-annual reports must contain at a minimum written documentation of: 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.		

Standard of Care	Routine Survey Deficiencies January 31 – February 5 and February 17 - 21, 2020	Verification Survey New and Repeat Deficiencies September 29 – October 23, 2020
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 # 1A37 Individual Specific Training *(Routine Survey - Upheld by IRF)*	**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 17: Training Requirements:** The purpose of this chapter is to outline requirements for completing, reporting and documenting DDSD training requirements for DD Waiver Provider Agencies as well as requirements for certified trainers or mentors of DDSD Core curriculum training. **17.1 Training Requirements for Direct Support Personnel and Direct Support Supervisors:** Direct Support Personnel (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports. 1. DSP/DSS must successfully: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in 17.10 Individual-Specific Training below. b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14 c. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements d. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. e. Complete relevant training in accordance with	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 ensure that Individual Specific Training requirements were met for 7 of 16 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Personnel (DSP):** • Individual Specific Training (#502, 503, 507, 509, 510, 511, 512) *(Note: Findings for DSP #502, 503, 507, 509, 510, 511, 512 are upheld by IRF, as documents were requested and not presented during the on-site survey)*	**Repeat Finding:** Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 1 of 12 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Personnel (DSP):** • Individual Specific Training (#511)

OSHA requirements (if job involves exposure to hazardous chemicals). f. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using EPR. Agency DSP and DSS shall maintain certification in a DDSD-approved system if any person they support has a BCIP that includes the use of EPR. g. Complete and maintain certification in a DDSD-approved medication course if required to assist with medication delivery. h. Complete training regarding the HIPAA. 2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings and be on shift with a DSP who has completed the relevant IST. **17.10 Individual-Specific Training:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they		

observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported. 1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends. 2. IST for therapy-related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher. 3. The competency level of the training is based on the IST section of the ISP. 4. The person should be present for and involved in IST whenever possible. 5. Provider Agencies are responsible for tracking of IST requirements. 6. Provider Agencies must arrange and ensure that DSP's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings. 7. If a therapist, BSC, nurse, or other author of a		

plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan. **17.10.1 IST Training Rosters:** IST Training Rosters are required for all IST trainings: 1. IST Training Rosters must include: a. the name of the person receiving DD Waiver services; b. the date of the training; c. IST topic for the training; d. the signature of each trainee; e. the role of each trainee (e.g., CIHS staff, CIE staff, family, etc.); and f. the signature and title or role of the trainer. 2. A competency-based training roster (required for CARMPs) includes all information above but also includes the level of training (awareness, knowledge, or skilled) the trainee has attained. (See Chapter 5.5 Aspiration Risk Management for more details about CARMPs.) 3. A copy of the training roster is submitted to the agency employing the staff trained within seven calendar days of the training date. The original is retained by the trainer.		

Standard of Care	Routine Survey Deficiencies January 31 – February 5 and February 17 - 21, 2020	Verification Survey New and Repeat Deficiencies September 29 – October 23, 2020
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**
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: 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: 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of January and February 2020. Based on record review, 2 of 3 individuals had Medication Administration Records (MAR), which contained missing medication entries and/or other errors: Individual #2 January 2020 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Super Carnosine 500mg (1 time daily) – Blank 1/3 (8 AM) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Arnica Drops (2 times daily) • Digestodoron Drops (2 times daily) • Super Carnosine 500mg (1 time daily) Individual #6 January 2020	**New / Repeat Finding:** After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the month of August 2020. Based on record review, 2 of 2 individuals had Medication Administration Records (MAR), which contained missing medication entries and/or other errors: Individual #2 August 2020 As indicated by the Medication Administration Records the Individual is to take Aurum METD/10 Ferrum met D17 / Sidereum D30 10 drops (2 times daily). According to the Physician's Orders Ferrum / Aurum Comp 10 drops is to be taken 1 time daily. Medication Administration Record and Physician's Orders do not match. Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Arnica D20 10 Drops (2 times daily) Individual #6 August 2020

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 assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; 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: 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. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training;	Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Buspirone 15mg (4 times daily) – Blank 1/30 (8 AM and 12 PM) • Cetirizine 10mg (1 time daily) – Blank 1/30 (8 AM) • Fluticasone Nasal Spray 5mg (1 time daily) – Blank 1/30 (8 AM)	Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Senna Plus 8.6mg (2 times daily) • Probiotic (1 time daily)

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
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: 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: 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;	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of January and February 2020 Based on record review, 1 of 3 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #2 January 2020 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Robitussin DM Cough Syrup – PRN – 1/2 (given 3 times), 1/4, 5 (given 2 times), and 1/9, 10 (given 1 time). • Tylenol 325mg – PRN – 1/2 (given 2 times),1/7, 14, 25 (given 1 time). No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Robitussin DM Cough Syrup – PRN – 1/6 -1/7. As indicated by the Medication Administration Records the individual is to take Acetaminophen 500mg (Every 4 hours as needed). According to the Physician's Orders, Acetaminophen 500mg is to be taken every 6 hours as needed. Medication Administration Record and Physician's Orders do not match.	**New / Repeat Findings:** After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the month of August 2020 Based on record review, 2 of 2 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #2 August 2020 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Acetaminophen 500mg (PRN) • Aurum D30 (PRN) • Imodium (PRN) Individual #6 August 2020 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Imodium (PRN) • Melatonin (PRN)

c. Documentation of all time limited or discontinued medications or treatments; 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; 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: 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. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD 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).		

Tag # 1A09.1.0 Medication Delivery PRN Medication Administration		Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: 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: 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;	**NA**	**New Findings:** Medication Administration Records (MAR) were reviewed for the month of August 2020 Based on record review, 2 of 2 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #2 August 2020 Medication Administration Records did not contain the exact amount to be used in a 24-hour period: • Imodium (PRN) • Melatonin (PRN) • Milk of Magnesia (PRN) • Mylanta / Maalox (PRN) • Pepto Bismol (PRN) • Robitussin DM (PRN) • Throat Lozenges (PRN) Individual #6 August 2020 Medication Administration Records did not contain the exact amount to be used in a 24-hour period: • Imodium (PRN) • Melatonin (PRN)

c. Documentation of all time limited or discontinued medications or treatments; 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; 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: 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. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD 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		• Milk of Magnesia (PRN) • Mylanta / Maalox (PRN) • Pepto Bismol (PRN) • Robitussin DM (PRN) • Throat Lozenges (PRN)

4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).		

Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	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 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: 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 (110^0 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	Based on record review and observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 3 of 4 Living Care Arrangement residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** • General-purpose first aid kit (#3, 6) • Emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#3, 6) *Note: The following Individuals share a residence:* ➢ #3, 6 **Family Living Requirements:** • Carbon monoxide detectors (#4, 5) • Poison Control Phone Number (#4, 5) • Emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 4, 5) • Emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy (#1) *Note: The following Individuals share a residence:* ➢ #4, 5	**Repeat Finding:** Based on record review and observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 1 of 3 Living Care Arrangement residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Family Living Requirements:** • Emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy (#1)

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 January 31 – February 5 and February 17 - 21, 2020	Verification Survey New and Repeat Deficiencies September 29 – October 23, 2020
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 # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components *(Routine Survey - Upheld by IRF)*	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	**Standard Level Deficiency**	**COMPLETE**
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**	**COMPLETE**
Tag # 1A22 Agency Personnel Competency	**Condition of Participation Level Deficiency**	**COMPLETE**
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 *(Routine Survey - Modified by IRF)*	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A09.0 Medication Delivery Routine Medication Administration	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A15 Healthcare Coordination - Nurse Availability / Knowledge *(Routine Survey - Upheld by IRF)*	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans) *(Routine Survey - Upheld by IRF)*	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider *(Routine Survey - Upheld by IRF)*	**Standard Level Deficiency**	**COMPLETE**
Tag # LS06 Family Living Requirements	**Standard Level Deficiency**	**COMPLETE**

Tag # LS25.1 Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living) ***(Routine Survey - Upheld by IRF)***	**Condition of Participation Level Deficiency**	**COMPLETE**
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*		
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag # LS26 Supported Living Reimbursement ***(Routine Survey - Upheld by IRF)***	**Standard Level Deficiency**	**COMPLETE**
Tag # LS27 Family Living Reimbursement ***(Routine Survey - Upheld by IRF)***	**Standard Level Deficiency**	**COMPLETE**

	Verification Survey Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements *(Routine Survey - Upheld by IRF)*	**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 # 1A37 Individual Specific Training *(Routine Survey - Upheld by IRF)*	**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 # 1A09 Medication Delivery Routine Medication Administration	**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 # 1A09.1 Medication Delivery PRN Medication Administration	**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 # 1A09.1.0 Medication Delivery PRN Medication Administration	**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 # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	**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

BILLY J. JIMENEZ
ACTING CABINET SECRETARY

Date:	December 1, 2020
To:	Glen Carlberg, Executive Director
Provider:	Collins Lake Center (Collins Lake Autism Center)
Address:	254 Encinal Road
State/Zip:	Cleveland, New Mexico 87715
E-mail Address:	glen.carlberg.cl@gmail.com
Region:	Northeast
Routine Survey:	January 31 – February 5 and February 17 - 21, 2020 *(Note: Survey extended due to inclement weather)*
Verification Survey:	September 29 – October 23, 2020
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Family Living, Customized Community Supports
Survey Type:	Verification

Dear Mr. Carlberg:

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

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