

Date (the date the letter is given to the Administrator; first day of the survey)

Agency Name
Name, Executive Director or CEO

During the course of this survey the team will need the following items:

1. Client files for: **(names of the individuals in the sample)**
2. A complete list of all Agency personnel with job title and original dates of hire, as well as the dates of any promotion to another position
3. Agency Personnel training records (*i.e. DDSD Core Training, Individual Specific Training, Transportation, Incident Management, etc.*) for all personnel who work with DD Waiver clients
4. Agency Personnel Caregiver Criminal History Screening (CCHS) records
5. Agency Personnel Employee Abuse Registry verification records
6. Access to Incident reports (internal or otherwise) for the previous 12 months
7. Access to Human Rights Committee minutes and/or approvals for the previous 12 months
8. Access to the Agency's Current and Complete Policy & Procedure Manual, including but not limited to the following:
 - Policy and procedure for Incident Management (*Internal or otherwise*).
 - Policy and procedure regarding frequency and purpose of the HRC
 - Procedures for emergency evacuation of homes and community sites / relocation of residents
 - Policy and procedure for on-call system, including nursing on-call
 - Policy and procedure for transportation
 - Policy and procedure for medication assistance and delivery
 - Policy and procedure for medication errors
 - Policy and procedure for storage of medication
 - Policy and procedure for Agency's Complaint / Grievance
 - Policy and procedure for Agency's Individuals Funds/Representative Payee
9. Documentation of annual evacuation drills for all residences
10. Documentation addressing the Agency's approach to the Employment First Principle
11. Documentation addressing Agency's approach to Meaningful Day
12. Documentation of Nursing contract(s) and current license(s) for all agency nurses.
13. If applicable, Written evidence of any exception to standard operations granted by the DDSD, New Mexico Board of Pharmacy or Board of Nursing
14. Documentation of Monthly Consultation, by agency supervisors or internal service coordinators, with the Family Living Direct Support Provider for months of: **Month, Month & Month Year** for each FL Individual Listed in #1 *****Surveyor REMOVE THIS ITEM (#12) if Agency DOES NOT PROVIDE FL Services.**
15. Copy of remittance records and supporting documentation for months of: **Month, Month & Month Year**
16. Copy of Medication Administration Records (front and back) for the months of **Month, Month & Month Year** for clients listed in #1
17. Copy of Physician's orders for All Routine & PRN Medications for the months covered in #13 for all individuals listed in #1 (aka the sample).
18. Copy of Quality Assurance / Quality Improvement Plan and Evidence of Meeting Minutes

19. Name and address for Chairperson of Board of Directors

Thank you in advance for you cooperation.

Name, Credentials

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

Agency Representative - Acknowledgement
of Receipt of Needs List