

Date: December 26, 2018

To: Lashell Harvey, Assistant Director  
 Provider: Expressions Unlimited, Co.  
 Address: 917 Pennsylvania NE  
 City, State, Zip: Albuquerque, New Mexico 87110

E-mail Address: [luvshell22@gmail.com](mailto:luvshell22@gmail.com)

Board Chair: Chris Henderson  
 E-Mail Address: [chrishen1390@gmail.com](mailto:chrishen1390@gmail.com)

Region: Metro  
 Survey Date: October 5 - 11, 2018  
 Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2007:** Supported Living, Adult Habilitation  
**2012 & 2018:** Supported Living, Customized Community Supports

Survey Type: Routine

Team Leader: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Member: Kandis Gomez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau and Lucio Hernandez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Harvey;

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

**Determination of Compliance:**

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

**Partial Compliance with 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 # LS14 Residential Service Delivery Site Case File (ISP and Healthcare requirements)
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A31 Client Rights/Human Rights

**DIVISION OF HEALTH IMPROVEMENT**  
 5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108  
 (505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

QMB Report of Findings – Expressions Unlimited, Co. – Metro – October 5 - 11, 2018



The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File (Other Required Documents)
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)
- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements
- Tag # LS14.1 Residential Service Delivery Site Case File (Other Required Documentation)
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)
- Tag # 5I44 Adult Habilitation Reimbursement
- Tag # IS30 Customized Community Supports Reimbursement
- Tag # LS26 Supported Living Reimbursement

**Plan of Correction:**

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

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (Attachment A) for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

**Corrective Action for Current Citation:**

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

**On-going Quality Assurance/Quality Improvement Processes:**

- What is going to be done on an ongoing basis? (i.e. file reviews, etc.)
- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position within your agency)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

**Submission of your Plan of Correction:**

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

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

1. **Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator  
1170 North Solano Suite D Las Cruces, New Mexico 88001**
2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

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

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

**Billing Deficiencies:**

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

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

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

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

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

**Request for Informal Reconsideration of Findings (IRF):**

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

Request for Informal Reconsideration of Findings  
5301 Central Ave NE Suite #400  
Albuquerque, NM 87108  
Attention: IRF request

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

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

Sincerely,

*Deb Russell, BS*

Deb Russell, BS  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Administrative Review Start Date:	October 5, 2018
Contact:	<b><u>Expressions Unlimited, Co.</u></b> Lashelle Harvey, Assistant Director  <b><u>DOH/DHI/QMB</u></b> Deb Russell, BS, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	October 9, 2018
Present:	<b><u>Expressions Unlimited, Co.</u></b> Lashelle Harvey, Assistant Director Charlaquice Bell, Healthcare Coordinator Chris Henderson, Director  <b><u>DOH/DHI/QMB</u></b> Deb Russell, BS, Healthcare Surveyor Kandis Gomez, AA, Healthcare Surveyor Lucio Hernandez, AA, Healthcare Surveyor
Exit Conference Date:	October 11, 2018
Present:	<b><u>Expressions Unlimited, Co.</u></b> Lashelle Harvey, Assistant Director Thelma Hilliard, Service Coordinator Chris Henderson, Director Charlaquice Bell, Healthcare Coordinator  <b><u>DOH/DHI/QMB</u></b> Deb Russell, BS, Healthcare Surveyor Kandis Gomez, AA, Healthcare Surveyor Lucio Hernandez, AA, Healthcare Surveyor  <b><u>DDSD – Metro Regional Office</u></b> Marie Velasco, Social Community Service Coordinator (Metro Region)
Administrative Locations Visited	1
Total Sample Size	8  2 - <i>Jackson</i> Class Members 6 - <i>Non-Jackson</i> Class Members  4 - Supported Living 6 - Customized Community Supports 2 - Adult Habilitation
Total Homes Visited	2
❖ Supported Living Homes Visited	2
	<i>Note: The following Individuals share a SL residence:</i> ➤ #1, 3 ➤ #6, 8
Persons Served Records Reviewed	8

Persons Served Interviewed	5
Persons Served Observed	3 (Three individuals chose not to participate in the interview process.)
Direct Support Personnel Interviewed	5
Direct Support Personnel Records Reviewed	13 (One DSP performs dual duties as a Service Coordinator)
Service Coordinator Records Reviewed	1 (One Service Coordinator performs dual duties as a DSP)
Administrative Interviews	1

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 A

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

#### **Introduction:**

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

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

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

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at [AmandaE.Castaneda@state.nm.us](mailto:AmandaE.Castaneda@state.nm.us). Requests for technical assistance must be requested through your Regional DDSD Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment C).

#### **Instructions for Completing Agency POC:**

##### **Required Content**

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice cited to prevent recurrence and information that ensures the regulation cited comes into and remains in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance (QA) Plan.

If a deficiency has already been corrected since the on-site survey, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

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

**The Plan of Correction must address each deficiency cited in the Report of Findings unless otherwise noted with a "No Plan of Correction Required statement." The Plan of Correction must address the five (5) areas listed below:**

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

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

- Details about how and when Individual Served, agency personnel and administrative and service delivery site files are audited by agency personnel to ensure they contain required documents;
- Information about how medication administration records are reviewed to verify they contain all required information before they are distributed to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (LOC) packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

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

### **Completion Dates**

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

### **Initial Submission of the Plan of Correction Requirements**

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

### **POC Document Submission Requirements**

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

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

**Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.**

## Attachment B

### Department of Health, Division of Health Improvement QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and 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 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.*

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

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

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

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

**Service Domain: Health, Welfare and Safety** - *The State, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*

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

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

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

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

## Attachment C

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

#### Introduction:

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

#### Instructions:

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

#### The following limitations apply to the IRF process:

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process.

**Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.

## QMB Determinations of Compliance

### **Compliance:**

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of *Compliance*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

### **Partial-Compliance with Standard Level Tags:**

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

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.
2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

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

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety.

### **Non-Compliance:**

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 17 or more Standard Level Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any tag.
2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Standard Level Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
COP Level Tags:	0 COP	0 COP	0 COP	0 COP	1 to 5 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%	
<b>“Non-Compliance”</b>						17 or more Standard Level Tags with 75 to 100% of the Individuals in the sample cited in any tag.	Any Amount of Standard Level Tags and 6 or more Conditions of Participation Level Tags.
<b>“Partial Compliance with Standard Level tags and Condition of Participation Level Tags”</b>					Any Amount of Standard level Tags, plus 1 to 5 Conditions of Participation Level tags.		
<b>“Partial Compliance with Standard Level tags”</b>			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.			
<b>“Compliance”</b>	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.					



<p>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 DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p><b>20.5.1 Individual Data Form (IDF):</b>  The Individual Data Form provides an overview of demographic information as well as other key personal, programmatic, insurance, and health related information. It lists medical information; assistive technology or adaptive equipment; diagnoses; allergies; information about whether a guardian or advance directives are in place; information about behavioral and health related needs; contacts of Provider Agencies and team members and other critical information. The IDF automatically loads information into other fields and forms and must be complete and kept current. This form is initiated by the CM. It must be opened and continuously updated by Living Supports, CCS- Group, ANS, CIHS and case management when applicable to the person in order for accurate data to auto populate other documents like the Health Passport and Physician Consultation Form. Although the Primary Provider Agency is ultimately responsible for keeping this form current, each provider collaborates and communicates critical information to update this form.</p>			
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**Chapter 3: Safeguards 3.1.2 Team Justification**

**Process:** DD Waiver participants may receive evaluations or reviews conducted by a variety of professionals or clinicians. These evaluations or reviews typically include recommendations or suggestions for the person/guardian or the team to consider. The team justification process includes:

1. Discussion and decisions about non-health related recommendations are documented on the Team Justification form.
2. The Team Justification form documents that the person/guardian or team has considered the recommendations and has decided:
  - a. to implement the recommendation;
  - b. to create an action plan and revise the ISP, if necessary; or
  - c. not to implement the recommendation currently.
3. All DD Waiver Provider Agencies participate in information gathering, IDT meeting attendance, and accessing supplemental resources if needed and desired.
4. The CM ensures that the Team Justification Process is followed and complete.

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015

**Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.



The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018  
**Chapter 6: Individual Service Plan (ISP)**  
**6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.

**Chapter 20: Provider Documentation and Client Records**  
**20.2 Client Records Requirements:** All 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>8. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.</p> <p>9. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices</p> <p>10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>11. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</p> <p>12. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>13. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>14. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p>			
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Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	Standard Level Deficiency		
<p><b>7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:</b>  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; Eff Date: 3/1/2018  <b>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:</b> 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:  1. Client records must contain all documents</p>	<p>Based on record review, the Agency did not complete written status reports as required for 6 of 8 individuals receiving Living Care Arrangements and Community Inclusion.</p> <p><b>Customized Community Supports Semi-Annual Reports:</b></p> <ul style="list-style-type: none"> <li>Individual #2 - Report not completed 14 days prior to the Annual ISP meeting (<i>Semi-Annual Report 2/2017 - 11/9/2017; Date Completed: 11/9/2017; ISP meeting held on 11/15/2017</i>).</li> <li>Individual #7 - Report not completed 14 days prior to the Annual ISP meeting (<i>Semi-Annual Report 8/2017 - 4/2018; Date Completed: 4/27/2018; ISP meeting held on 4/16/2018</i>).</li> </ul> <p><b>Nursing Semi-Annual / Quarterly Reports:</b></p> <ul style="list-style-type: none"> <li>Individual #2 - Report not completed 14 days prior to the Annual ISP meeting (<i>Semi-Annual Report 8/27/2017 - 11/15/2017; Date Completed: 11/15/2017; ISP meeting held on 11/15/2017</i>).</li> <li>Individual #4- None found for 8/2017 - 7/2018 (<i>Term of ISP 5/1/2017 - 4/30/2018; 5/1/2018 - 4/30/2019. ISP meeting held on 3/7/2018</i>).</li> <li>Individual #5 - None found for 10/2017 - 4/2018. (<i>Term of ISP 10/30/2017 - 10/29/2018</i>).</li> <li>Individual #7 - None found for 7/2017 - 1/2018 (<i>Term of ISP 7/17/2017 - 7/16/2018</i>).</li> <li>Individual #8 - None found for 8/2017 - 3/2018. (<i>Term of ISP 8/20/2017 - 8/19/2018. ISP meeting held on 5/2/2018. Report found</i></li> </ul>	<p><b>Provider:</b>  State your Plan of Correction for the deficiencies cited in this tag here (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p><b>Provider:</b>  Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (<i>What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →  </p>	

<p>essential to the service being provided and 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> <p><b>Chapter 19: Provider Reporting</b>  <b>Requirements: 19.5 Semi-Annual Reporting:</b>  The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to</p>	<p><i>covered 4/2018 - 5/2018).</i></p>		
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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 DDS 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

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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.

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare requirements)	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:</b> 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"> <li>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.</li> <li>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.</li> <li>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</li> <li>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.</li> <li>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.</li> <li>6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency</li> </ol>	<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 a complete and confidential case file in the residence for 2 of 4 Individuals receiving Living Care Arrangements.</p> <p>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p><b>ISP Teaching and Support Strategies:</b></p> <p><b>Individual #1:</b> TSS not found for the following Live Outcome Statement / Action Steps:</p> <ul style="list-style-type: none"> <li>• "...will attend new social events that he has never attended before."</li> </ul> <p><b>Healthcare Passport:</b></p> <ul style="list-style-type: none"> <li>• Did not contain Physician contact information (#8)</li> </ul>	<p><b>Provider:</b> <b>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?):</b> →</p> <p><b>Provider:</b> <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</b> →  </p>	<p>  </p>

<p>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 DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p><b>20.5.3 Health Passport and Physician Consultation Form:</b> All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form. The Physician Consultation form contains a list of all current medications. Requirements for the Health Passport and Physician Consultation form are:</p> <p>2. The Primary and Secondary Provider Agencies must ensure that a current copy of the Health Passport and Physician Consultation forms are printed and available at all service delivery sites. Both forms must be reprinted and placed at all service delivery sites each time the e-CHAT is updated for any reason and whenever there is a change to contact information contained in the IDF.</p> <p><b>Chapter 13: Nursing Services:</b>  <b>13.2.9 Healthcare Plans (HCP):</b>  1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim</p>			
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plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans.

2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary

**13.2.10 Medical Emergency Response Plan (MERP):**

1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP.

2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015

**CHAPTER 11 (FL) 3. Agency Requirements**

**C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.

Tag # LS14.1 Residential Service Delivery Site Case File (Other Required Documentation)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:</b> 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"> <li>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.</li> <li>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.</li> <li>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</li> <li>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.</li> <li>5. Each Provider Agency is responsible for maintaining the daily or other contact notes</li> </ol>	<p>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 4 Individuals receiving Living Care Arrangements.</p> <p>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p><b>Speech Therapy Plan (Therapy Intervention Plan):</b></p> <ul style="list-style-type: none"> <li>• Not Found (#6)</li> </ul>	<p><b>Provider:</b>  <b>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?):</b> →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</b> →  </p>	<p>  </p>

<p>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 DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>CHAPTER 11 (FL) 3. Agency Requirements</b></p> <p>C. Residence Case File: The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDS Individual Case File Matrix policy.</p>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<b>Service Domain: Health and Welfare</b> - 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.			
<b>Tag # 1A08.2 Administrative Case File: Healthcare Requirements &amp; Follow-up</b>	<b>Condition of Participation Level Deficiency</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 3 Safeguards: 3.1.1 Decision Consultation Process (DCP):</b> Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following:</p> <p>1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to:</p> <p>a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;</p> <p>b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy;</p> <p>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and</p> <p>d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive</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 and interview, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 3 of 8 individuals receiving Living Care Arrangements and Community Inclusion.</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p><b>Community Inclusion Services (Individuals Receiving Inclusion Services Only):</b></p> <p><b>Dental Exam:</b></p> <ul style="list-style-type: none"> <li>Individual #5 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</li> </ul> <p><b>Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):</b></p> <p><b>Dental Exam:</b></p> <ul style="list-style-type: none"> <li>Individual #8 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</li> </ul> <p><b>Vision Exam:</b></p> <ul style="list-style-type: none"> <li>Individual #3 - As indicated by collateral documentation reviewed, exam was completed on 7/5/2016. Follow-up was to be</li> </ul>	<p><b>Provider:</b>  <b>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?):</b> →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</b> →  </p>	<p>  </p>

<p>Aspiration Risk Management Plan (CARMP), or another plan.</p> <p>2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting:</p> <p>a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation.</p> <p>b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation.</p> <p>c. Providers support the person/guardian to make an informed decision.</p> <p>d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.</p> <p><b>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:</b> 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>	<p>completed in 1 - 2 years. No evidence of follow-up found.</p> <p><b>Cholesterol and Blood Glucose:</b></p> <ul style="list-style-type: none"> <li>• Individual #3 - As indicated by collateral documentation reviewed, lab work was ordered on 5/17/2018. No evidence of lab results were found.</li> </ul>		
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<p>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.</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> <p><b>20.5.3 Health Passport and Physician Consultation Form:</b> All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the</p>			
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<p>Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form. The Physician Consultation form contains a list of all current medications.</p> <p><b>Chapter 10: Living Care Arrangements (LCA) Living Supports-Supported Living: 10.3.9.6.1 Monitoring and Supervision</b></p> <p>4. Ensure and document the following:</p> <ul style="list-style-type: none"> <li>a. The person has a Primary Care Practitioner.</li> <li>b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist.</li> <li>c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist.</li> <li>d. The person receives a hearing test as recommended by a licensed audiologist.</li> <li>e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist.</li> </ul> <p>5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine).</p> <p><b>Chapter 13 Nursing Services: 13.2.3 General Requirements:</b></p> <p>1. Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information.</p>			
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<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>Chapter 6 (CCS) 3. Agency Requirements:</b>  G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDS Individual Case File Matrix policy.</p> <p><b>Chapter 12 (SL) 3. Agency Requirements:</b>  D. Consumer Records Policy: Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDS Individual Case File Matrix policy.</p> <p><b>DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDS): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications:</b>  A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.</p> <p>H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.</p>			
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Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:</b> 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"> <li>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.</li> <li>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.</li> <li>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</li> <li>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.</li> <li>5. Each Provider Agency is responsible for maintaining the daily or other contact notes</li> </ol>	<p>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 1 of 8 individuals.</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p><b>Comprehensive Aspiration Risk Management Plan (CARMP):</b></p> <ul style="list-style-type: none"> <li>• Not Current (#5)</li> </ul>	<p><b>Provider:</b>  <b>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?):</b> →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</b> →  </p>	<p>  </p>

<p>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 DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p><b>Chapter 3 Safeguards: 3.1.1 Decision Consultation Process (DCP):</b> Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following:</p> <p>1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;</li> <li>b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-</li> </ul>			
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<p>fluoroscopy;</p> <p>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and</p> <p>d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.</p> <p>2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting:</p> <p>a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation.</p> <p>b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation.</p> <p>c. Providers support the person/guardian to make an informed decision.</p> <p>d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.</p> <p><b>Chapter 13 Nursing Services:</b>  <b>13.2.5 Electronic Nursing Assessment and Planning Process:</b> The nursing assessment process includes several DDSO mandated tools: the electronic Comprehensive Nursing Assessment Tool (e-CHAT), the Aspiration Risk Screening Tool (ARST) and the Medication</p>			
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<p>Administration Assessment Tool (MAAT) . This process includes developing and training Health Care Plans and Medical Emergency Response Plans.</p> <p>The following hierarchy is based on budgeted services and is used to identify which Provider Agency nurse has primary responsibility for completion of the nursing assessment process and related subsequent planning and training. Additional communication and collaboration for planning specific to CCS or CIE services may be needed.</p> <p>The hierarchy for Nursing Assessment and Planning responsibilities is:</p> <ol style="list-style-type: none"> <li>1. Living Supports: Supported Living, IMLS or Family Living via ANS;</li> <li>2. Customized Community Supports- Group; and</li> <li>3. Adult Nursing Services (ANS):       <ol style="list-style-type: none"> <li>a. for persons in Community Inclusion with health-related needs; or</li> <li>b. if no residential services are budgeted but assessment is desired and health needs may exist.</li> </ol> </li> </ol> <p><b>13.2.6 The Electronic Comprehensive Health Assessment Tool (e-CHAT)</b></p> <ol style="list-style-type: none"> <li>1. The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person.</li> <li>2. The nurse must see the person face-to-face to complete the nursing assessment. Additional information may be gathered from members of the IDT and other sources.</li> <li>3. An e-CHAT is required for persons in FL, SL, IMLS, or CCS-Group. All other DD Waiver recipients may obtain an e-CHAT if needed or desired by adding ANS hours for assessment and consultation to their budget.</li> <li>4. When completing the e-CHAT, the nurse is required to review and update the electronic record and consider the diagnoses, medications,</li> </ol>			
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<p>treatments, and overall status of the person. Discussion with others may be needed to obtain critical information.</p> <p>5. The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections.</p> <p><b>13.2.7 Aspiration Risk Management Screening Tool (ARST)</b></p> <p><b>13.2.8 Medication Administration Assessment Tool (MAAT):</b></p> <p>1. A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting.</p> <p>2. After completion of the MAAT, the nurse will present recommendations regarding the level of assistance with medication delivery (AWMD) to the IDT. A copy of the MAAT will be sent to all the team members two weeks before the annual ISP meeting and the original MAAT will be retained in the Provider Agency records.</p> <p>3. Decisions about medication delivery are made by the IDT to promote a person's maximum independence and community integration. The IDT will reach consensus regarding which criteria the person meets, as indicated by the results of the MAAT and the nursing recommendations, and the decision is documented this in the ISP.</p> <p><b>13.2.9 Healthcare Plans (HCP):</b></p> <p>1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for</p>			
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<p>aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans.</p> <p>2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs plans that the nurse determines are warranted.</p> <p><b>13.2.10 Medical Emergency Response Plan (MERP):</b></p> <p>1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP.</p> <p>2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.</p> <p><b>Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and Physician Consultation Form:</b> All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety</p>			
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<p>risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>Chapter 6 (CCS) 2. Service Requirements. E.</b> The agency nurse(s) for Customized Community Supports providers must provide the following services: 1. Implementation of pertinent PCP orders; ongoing oversight and monitoring of the individual's health status and medically related supports when receiving this service;</p> <p><b>3. Agency Requirements: Consumer Records Policy:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p><b>Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy:</b> ...Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p>			
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Tag # 1A31 Client Rights/Human Rights	Condition of Participation Level Deficiency		
<p><b>NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:</b></p> <p>A. A service provider shall not restrict or limit a client's rights except:</p> <p>(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or</p> <p>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</p> <p>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</p> <p>B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.</p> <p>C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 2: Human Rights:</b> Civil rights apply to everyone, including all waiver participants, family members, guardians, natural supports, and Provider Agencies. Everyone has a responsibility to make sure those rights are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an</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 ensure the rights of Individuals was not restricted or limited for 4 of 8 Individuals.</p> <p>A review of Agency Individual files found no documentation of Positive Behavior Plans and/or Positive Behavior Crisis Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (Individual #2, 5, 7, 8)</p> <p><b>No documentation was found regarding Human Rights Approval for the following:</b></p> <ul style="list-style-type: none"> <li>• Physical Restraint (Individual #2, 7, 8)</li> <li>• Use of 911 (#5)</li> <li>• Locked Sharps (#8)</li> </ul>	<p><b>Provider:</b>  <b>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?):</b> →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</b> → ]</p>	<p>[ ]</p>

<p>obligation to contribute to the planning process, always focusing on how to best support the person.</p> <p><b>Chapter 3 Safeguards: 3.3.1 HRC Procedural Requirements:</b></p> <ol style="list-style-type: none"> <li>1. An invitation to participate in the HRC meeting of a rights restriction review will be given to the person (regardless of verbal or cognitive ability), his/her guardian, and/or a family member (if desired by the person), and the Behavior Support Consultant (BSC) at least 10 working days prior to the meeting (except for in emergency situations). If the person (and/or the guardian) does not wish to attend, his/her stated preferences may be brought to the meeting by someone whom the person chooses as his/her representative.</li> <li>2. The Provider Agencies that are seeking to temporarily limit the person's right(s) (e.g., Living Supports, Community Inclusion, or BSC) are required to support the person's informed consent regarding the rights restriction, as well as their timely participation in the review.</li> <li>3. The plan's author, designated staff (e.g., agency service coordinator) and/or the CM makes a written or oral presentation to the HRC.</li> <li>4. The results of the HRC review are reported in writing to the person supported, the guardian, the BSC, the mental health or other specialized therapy provider, and the CM within three working days of the meeting.</li> <li>5. HRC committees are required to meet at least on a quarterly basis.</li> <li>6. A quorum to conduct an HRC meeting is at least three voting members eligible to vote in each situation and at least one must be a community member at large.</li> <li>7. HRC members who are directly involved in the services provided to the person must excuse themselves from voting in that situation.</li> </ol> <p>Each HRC is required to have a provision for emergency approval of rights restrictions based</p>			
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<p>upon credible threats of harm against self or others that may arise between scheduled HRC meetings (e.g., locking up sharp knives after a serious attempt to injure self or others or a disclosure, with a credible plan, to seriously injure or kill someone). The confidential and HIPAA compliant emergency meeting may be via telephone, video or conference call, or secure email. Procedures may include an initial emergency phone meeting, and a subsequent follow-up emergency meeting in complex and/or ongoing situations.</p> <p>8. The HRC with primary responsibility for implementation of the rights restriction will record all meeting minutes on an individual basis, i.e., each meeting discussion for an individual will be recorded separately, and minutes of all meetings will be retained at the agency for at least six years from the final date of continuance of the restriction.</p> <p><b>3.3.3 HRC and Behavioral Support:</b> The HRC reviews temporary restrictions of rights that are related to medical issues or health and safety considerations such as decreased mobility (e.g., the use of bed rails due to risk of falling during the night while getting out of bed). However, other temporary restrictions may be implemented because of health and safety considerations arising from behavioral issues. Positive Behavioral Supports (PBS) are mandated and used when behavioral support is needed and desired by the person and/or the IDT. PBS emphasizes the acquisition and maintenance of positive skills (e.g. building healthy relationships) to increase the person's quality of life understanding that a natural reduction in other challenging behaviors will follow. At times, aversive interventions may be temporarily included as a part of a person's behavioral support (usually in the BCIP), and therefore, need to be reviewed prior to implementation as well as periodically while the</p>			
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<p>restrictive intervention is in place. PBSPs not containing aversive interventions do not require HRC review or approval.</p> <p>Plans (e.g., ISPs, PBSPs, BCIPs PPMPs, and/or RMPs) that contain any aversive interventions are submitted to the HRC in advance of a meeting, except in emergency situations.</p> <p><b>3.3.4 Interventions Requiring HRC Review and Approval:</b> HRCs must review prior to implementation, any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies, including but not limited to:</p> <ol style="list-style-type: none"> <li>1. response cost;</li> <li>2. restitution;</li> <li>3. emergency physical restraint (EPR);</li> <li>4. routine use of law enforcement as part of a BCIP;</li> <li>5. routine use of emergency hospitalization procedures as part of a BCIP;</li> <li>6. use of point systems;</li> <li>7. use of intense, highly structured, and specialized treatment strategies, including level systems with response cost or failure to earn components;</li> <li>8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons;</li> <li>9. use of PRN psychotropic medications;</li> <li>10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand);</li> <li>11. use of bed rails;</li> <li>12. use of a device and/or monitoring system through PST may impact the person's privacy or other rights; or</li> <li>13. use of any alarms to alert staff to a person's whereabouts.</li> </ol> <p><b>3.4 Emergency Physical Restraint (EPR):</b> Every person shall be free from the use of restrictive physical crisis intervention measures that are unnecessary. Provider Agencies who support people who may occasionally need</p>			
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<p>intervention such as Emergency Physical Restraint (EPR) are required to institute procedures to maximize safety.</p> <p><b>3.4.5 Human Rights Committee:</b> The HRC reviews use of EPR. The BCIP may not be implemented without HRC review and approval whenever EPR or other restrictive measure(s) are included. Provider Agencies with an HRC are required to ensure that the HRCs:</p> <ol style="list-style-type: none"> <li>1. participate in training regarding required constitution and oversight activities for HRCs;</li> <li>2. review any BCIP, that include the use of EPR;</li> <li>3. occur at least annually, occur in any quarter where EPR is used, and occur whenever any change to the BCIP is considered;</li> <li>4. maintain HRC minutes approving or disallowing the use of EPR as written in a BCIP; and</li> <li>5. maintain HRC minutes of meetings reviewing the implementation of the BCIP when EPR is used.</li> </ol>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<b>Service Domain: Medicaid Billing/Reimbursement</b> - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.			
<b>Tag # 5144 Adult Habilitation Reimbursement</b>	<b>Standard Level Deficiency</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p><b>B. Billable Units:</b> The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <p>(1) Date, start and end time of each service encounter or other billable service interval;</p> <p>(2) A description of what occurred during the encounter or service interval; and</p> <p>(3) The signature or authenticated name of staff providing the service.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 XVI. REIMBURSEMENT</b></p> <p><b>A. Billable Unit.</b> A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care.</p> <p><b>B. Billable Activities</b></p> <p>(1) The Community Inclusion Provider Agency can bill for those activities listed and described</p>	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 1 of 2 individuals.</p> <p>Individual #4 August 2018</p> <ul style="list-style-type: none"> <li>The Agency billed 22 units of Adult Habilitation (T2021 U1) on 8/7/2018. Documentation received accounted for 18 units. (Note: Void/adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)</li> <li>The Agency billed 24 units of Adult Habilitation (T2021 U1) on 8/27/2018. Documentation received accounted for 22 units. (Note: Void/adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)</li> </ul> <p>September 2018</p> <ul style="list-style-type: none"> <li>The Agency billed 24 units of Adult Habilitation (T2021 U1) on 9/10/2018. Documentation received accounted for 20 units. (Note: Void/adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)</li> </ul>	<p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →  </p>	<p>  </p>

<p>on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours.</p> <p>(2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours</p> <p><b>NMAC 8.302.1.17 Effective Date 9-15-08 Record Keeping and Documentation Requirements</b> - A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.</p> <p><b>Detail Required in Records</b> - Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed, diagnosis and medical necessity of any service . . . Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.</p> <p><b>Services Billed by Units of Time</b> - Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.</p> <p><b>Records Retention</b> - A provider who receives payment for treatment, services or goods must</p>			
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retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

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

Tag # IS30 Customized Community Supports Reimbursement	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:</b> DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> <li>1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing.</li> <li>2. Comprehensive documentation of direct service delivery must include, at a minimum: <ol style="list-style-type: none"> <li>a. the agency name;</li> <li>b. the name of the recipient of the service;</li> <li>c. the location of the service;</li> <li>d. the date of the service;</li> <li>e. the type of service;</li> <li>f. the start and end times of the service;</li> <li>g. the signature and title of each staff member who documents their time; and</li> <li>h. the nature of services.</li> </ol> </li> <li>3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer.</li> <li>4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date: <ol style="list-style-type: none"> <li>a. treatment or care of any eligible recipient;</li> <li>b. services or goods provided to any eligible recipient;</li> <li>c. amounts paid by MAD on behalf of any</li> </ol> </li> </ol>	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 1 of 6 individuals.</p> <p>Individual #1 July 2018</p> <ul style="list-style-type: none"> <li>• The Agency billed 40 units of Customized Community Supports (Group) (T2021 HB U8) on 7/31/2018. Documentation received accounted for 20 units. <i>(Note: Void/adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)</i></li> </ul>	<p><b>Provider:</b> <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →  </p>	<p>  </p>

eligible recipient; and  
d. any records required by MAD for the administration of Medicaid.

**21.9 Billable Units:** The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units.

**21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following:

1. A day is considered 24 hours from midnight to midnight.
2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period.
3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months.
4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows:
  - a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%).
  - b. The receiving Provider Agency bills the remaining days up to 340 for the ISP year.

**21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following:

1. A month is considered a period of 30 calendar days.
2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is

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<p>billed.</p> <p>3. Monthly units can be prorated by a half unit.</p> <p>4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit.</p> <p><b>21.9.3 Requirements for 15-minute and hourly units:</b> For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:</p> <p>1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2.</p> <p>2. Services that last in their entirety less than eight minutes cannot be billed.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>CHAPTER 6 (CCS) 4. REIMBURSEMENT</b></p> <p><b>A. Required Records:</b> Customized Community Supports Services Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. Customized Community Supports Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.</p> <p><b>B. Billable Unit:</b></p> <p>1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit.</p> <p>2. The billable unit for Community Inclusion Aide</p>			
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<p>is a fifteen (15) minute unit.</p> <p>3. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group assignment.</p> <p>4. The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Customized Community Supports without prior approval from DDSD.</p> <p>5. The billable unit for Individual Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit.</p> <p>6. The billable unit for Fiscal Management for Adult Education is one dollar per unit including a 10% administrative processing fee.</p> <p>7. The billable units for Adult Nursing Services are addressed in the Adult Nursing Services Chapter.</p> <p><b>C. Billable Activities: All DSP activities that are:</b></p> <ul style="list-style-type: none"> <li>a. Provided face to face with the individual;</li> <li>b. Described in the individual's approved ISP;</li> <li>c. Provided in accordance with the Scope of Services; and</li> <li>d. Activities included in billable services, activities or situations.</li> </ul>			
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Tag # LS26 Supported Living Reimbursement	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:</b> DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> <li>1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing.</li> <li>2. Comprehensive documentation of direct service delivery must include, at a minimum: <ol style="list-style-type: none"> <li>a. the agency name;</li> <li>b. the name of the recipient of the service;</li> <li>c. the location of the service;</li> <li>d. the date of the service;</li> <li>e. the type of service;</li> <li>f. the start and end times of the service;</li> <li>g. the signature and title of each staff member who documents their time; and</li> <li>h. the nature of services.</li> </ol> </li> <li>3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer.</li> <li>4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date: <ol style="list-style-type: none"> <li>a. treatment or care of any eligible recipient;</li> <li>b. services or goods provided to any eligible recipient;</li> <li>c. amounts paid by MAD on behalf of any</li> </ol> </li> </ol>	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 1 of 4 individuals.</p> <p>Individual #3 September 2018</p> <ul style="list-style-type: none"> <li>• The Agency billed 1 unit of Supported Living (T2016 HB U6) on 9/13/2018. Documentation received accounted for .5 units. <i>(Note: Void/adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)</i></li> </ul>	<p><b>Provider:</b> <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →  </p>	<p>  </p>

<p>eligible recipient; and</p> <p>d. any records required by MAD for the administration of Medicaid.</p> <p><b>21.9 Billable Units:</b> The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units.</p> <p><b>21.9.1 Requirements for Daily Units:</b> For services billed in daily units, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> <li>1. A day is considered 24 hours from midnight to midnight.</li> <li>2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period.</li> <li>3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months.</li> <li>4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows: <ol style="list-style-type: none"> <li>a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%).</li> <li>b. The receiving Provider Agency bills the remaining days up to 340 for the ISP year.</li> </ol> </li> </ol> <p><b>21.9.2 Requirements for Monthly Units:</b> For services billed in monthly units, a Provider Agency must adhere to the following:</p> <ol style="list-style-type: none"> <li>1. A month is considered a period of 30 calendar days.</li> <li>2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed.</li> <li>3. Monthly units can be prorated by a half unit.</li> <li>4. Agency transfers not occurring at the</li> </ol>			
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<p>beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit.</p> <p><b>21.9.3 Requirements for 15-minute and hourly units:</b> For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> <li>1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2.</li> <li>2. Services that last in their entirety less than eight minutes cannot be billed.</li> </ol>			
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Date: March 15, 2019

To: Lashell Harvey, Assistant Director  
Provider: Expressions Unlimited, Co.  
Address: 917 Pennsylvania NE  
City, State, Zip: Albuquerque, New Mexico 87110

E-mail Address: [luvshell22@gmail.com](mailto:luvshell22@gmail.com)

Board Chair: Chris Henderson  
E-Mail Address: [chrishen1390@gmail.com](mailto:chrishen1390@gmail.com)

Region: Metro  
Survey Date: October 5 - 11, 2018  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: **2007:** Supported Living, Adult Habilitation  
**2012 & 2018:** Supported Living, Customized Community Supports  
Survey Type: Routine

Dear Ms. Harvey;

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

**The Plan of Correction process is now complete.**

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

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

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

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

Sincerely,

*Amanda Castañeda*

Amanda Castañeda  
Plan of Correction Coordinator  
Quality Management Bureau/DHI

Q.19.2.DDW.91028761.5.RTN.09.19.074