

MICHELLE LUJAN GRISHAM Governor

DAVID R. SCRASE, M.D. Acting Cabinet Secretary

Date: March 18, 2022

To: Joseph Garcia, Executive Director

Provider: Advantage Communication Systems, Inc.

Address: 4219 Montgomery Blvd NE

State/Zip: Albuquerque, New Mexico 87109

E-mail Address: josephgarcia.adv@gmail.com

CC: Laura Veal, Owner

E-mail Address: <u>lsveal@yahoo.com</u>

Region: Metro

Survey Date: January 3 – 14, 2022

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Supported Living, Customized Community Supports, and Community Integrated Employment

Services

Survey Type: Routine

Team Leader: Heather Driscoll, AA, Healthcare Surveyor, Division of Health Improvement/Quality

Management Bureau

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

Bureau; Sally Rel, MS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Caitlin Wall, BA, Healthcare Surveyor, Division of Health

Improvement/Quality Management Bureau

Dear Mr. Joseph Garcia,

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:

Non-Compliance: This determination is based on noncompliance with 17 or more total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level tag or any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags (refer to Attachment

DIVISION OF HEALTH IMPROVEMENT

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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 # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components
- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation
- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A25.1 Caregiver Criminal History Screening
- Tag # 1A37 Individual Specific Training
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A09 Medication Delivery Routine Medication Administration
- Tag # 1A09.1 Medication Delivery PRN Medication Administration
- Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medications
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)
- Tag # 1A31 Client Human Rights

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File (Other Required Documents)
- Tag # 1A08.1 Administrative and Residential Case File: Progress Notes
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)
- Tag # 1A43.1 General Events Reporting: Individual Reporting
- Tag # 1A09.0 Medication Delivery Routine Medication Administration
- Tag # 1A09.1.0 Medication Delivery PRN Medication Administration
- Tag # 1A27.2 Duty to Report IR Filed During On-Site and/or IRs Not Reported by Provider
- Tag # LS25 Residential Health & Safety (Supported Living & Family Living)
- Tag # IS25 Community Integrated Employment Services / Supported Employment 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: Monica Valdez, Plan of Correction Coordinator in any of the following ways:
 - a. Electronically at MonicaE. Valdez@state.nm.us (preferred method)
 - b. Fax to 505-222-8661, or
 - c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108
- 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
1474 Rodeo Road
Santa Fe. New Mexico 87505

If you have questions and would like to speak with someone at HSD/OIG/PIU, please contact:

Lisa Medina-Lujan (Lisa.medina-lujan @state.nm.us)

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:

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

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 contact the Plan of Correction Coordinator, <u>Monica Valdez at 505-273-1930 or email at:</u> <u>MonicaE.Valdez@state.nm.us</u> 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,

Heather I. Driscoll, AA

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

Heather L. Driscoll, AA

Survey Process Employed: Administrative Review Start Date: January 3, 2022 Contact: Advantage Communication Systems, Inc. Joseph Garcia, Executive Director DOH/DHI/QMB Heather Driscoll, AA, Team Lead/Healthcare Surveyor On-site Entrance Conference Date: January 3, 2022 Present: Advantage Communication Systems, Inc. Eli Garcia, Quality Control Joseph Garcia, Executive Director Michelle Rodriguez, RN Laura Veal, Owner Michael Tamasi, CFO Melissa Velasquez, DSL Director DOH/DHI/QMB Heather Driscoll, AA, Team Lead/Healthcare Surveyor Lora Norby, Healthcare Surveyor Sally Rel, MS, Healthcare Surveyor Caitlin Wall, BA, Healthcare Surveyor Exit Conference Date: January 14, 2022 Present: Advantage Communication Systems, Inc. Eli Garcia, Quality Control Joseph Garcia, Executive Director Michelle Rodriguez, RN Laura Veal, Owner DOH/DHI/QMB Heather Driscoll, AA, Team Lead/Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Lora Norby, Healthcare Surveyor Sally Rel, MS, Healthcare Surveyor Caitlin Wall, BA, Healthcare Surveyor **DDSD - METRO Regional Office** Linda Clark, Assistant Regional Director Michael Driskell, Regional Director Maura Emerine-Danbury, State Service Coordinator Generalist Total Sample Size: 18 1 - Jackson Class Members 17 - Non-Jackson Class Members 9 - Supported Living (Note:9 additional Individuals were seen

8 - Customized Community Supports (Note: 8 additional Individuals were seen for billing and training for a total of 16)
5 - Community Integrated Employment (Note: 3 additional

for billing and training for a total of 18)

5 - Community Integrated Employment (Note: 3 additional Individuals were seen for billing and training for a total of 8)

Total Homes Visited 8

Supported Living Homes Visited

Note: The following Individuals share a SL

residence: ➤ #7,8

Persons Served Records Reviewed 18

Persons Served Interviewed 7

Persons Served Observed 1

Persons Served Not Seen and/or Not Available 1 (Note: One Individual was not available during the onsite

survey.)

Direct Support Personnel Records Reviewed 73 (Note: Two DSP perform dual roles as Service

Coordinators)

Direct Support Personnel Interviewed 10 (Note: Interviews conducted by video / phone due to

COVID- 19 Public Health Emergency)

Service Coordinator Records Reviewed 8 (Note: Two Service Coordinators perform dual roles as DSP)

Nurse Interview 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
- 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 DOH – Internal Review Committee

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 505-273-1930 or email at MonicaE.Valdez@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, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@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 Monica Valdez, POC Coordinator in any of the following ways:
 - a. Electronically at MonicaE. Valdez@state.nm.us (preferred method)
 - b. Fax to 505-222-8661, or
 - c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108
- <u>Do not submit supporting documentation</u> (evidence of compliance) to QMB <u>until after</u> 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 <u>must be annotated</u>; 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 completion 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 nonnegotiable Conditions of Participation, regardless of 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:

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

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

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

<u>Service Domain: Qualified Providers -</u> The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.

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

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

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

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

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

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

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

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

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

Attachment C

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

Introduction:

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

Instructions:

- The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Bureau
 Chief <u>within 10 business days</u> of receipt of the final Report of Findings (*Note: No extensions are granted for the IRF*).
- 2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: https://nmhealth.org/about/dhi/cbp/irf/
- 3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
- 4. The IRF request must include all supporting documentation or evidence.
- 5. If you have questions about the IRF process, email the IRF Chairperson, Valerie V. Valdez at valerie.valdez@state.nm.us for assistance.

The following limitations apply to the IRF process:

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.

Attachment D

QMB Determinations of Compliance

Compliance:

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

Partial-Compliance with Standard Level Tags:

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

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

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

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

Non-Compliance:

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

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

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

Agency: Advantage Communication Systems, Inc. - Metro Region

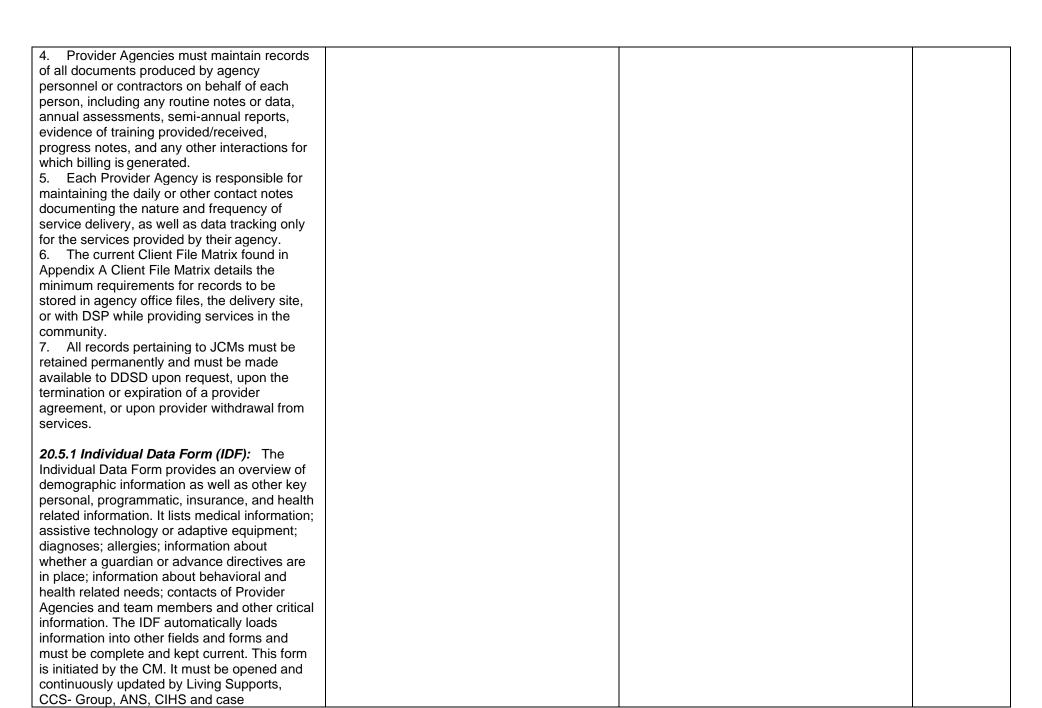
Program: Developmental Disabilities Waiver

Service: Supported Living, Customized Community Supports, and Community Integrated Employment Services

Survey Type: Routine

Survey Date: January 3 – 14, 2022

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
	ntation – Services are delivered in accordance wi	ith the service plan, including type, scope, amount,	duration and
frequency specified in the service plan.			
Tag # 1A08 Administrative Case File (Other	Standard Level Deficiency		
Required Documents)			
Developmental Disabilities (DD) Waiver	Based on record review, the Agency did not	Provider:	
Service Standards 2/26/2018; Re-Issue:	maintain a complete and confidential case file	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	at the administrative office for 3 of 9	deficiencies cited in this tag here (How is the	
Chapter 20: Provider Documentation and	individuals.	deficiency going to be corrected? This can be	
Client Records: 20.2 Client Records		specific to each deficiency cited or if possible, an	
Requirements: All DD Waiver Provider	Review of the Agency administrative individual	overall correction?): \rightarrow	
Agencies are required to create and maintain	case files revealed the following items were not		
individual client records. The contents of client	found, incomplete, and/or not current:		
records vary depending on the unique needs			
of the person receiving services and the	Speech Therapy Plan (Therapy Intervention		
resultant information produced. The extent of	Plan TIP):		
documentation required for individual client	• Not Found (#1, 6)		
records per service type depends on the			
location of the file, the type of service being	Physical Therapy Plan (Therapy	Provider:	
provided, and the information necessary.	Intervention Plan TIP):	Enter your ongoing Quality	
DD Waiver Provider Agencies are required to	Not Found (#7)	Assurance/Quality Improvement	
adhere to the following:	,	processes as it related to this tag number	
1. Client records must contain all documents		here (What is going to be done? How many	
essential to the service being provided and		individuals is this going to affect? How often will	
essential to ensuring the health and safety of		this be completed? Who is responsible? What	
the person during the provision of the service.		steps will be taken if issues are found?): →	
2. Provider Agencies must have readily			
accessible records in home and community			
settings in paper or electronic form. Secure			
access to electronic records through the			
Therap web-based system using computers or			
mobile devices is acceptable.			
3. Provider Agencies are responsible for			
ensuring that all plans created by nurses, RDs,			
therapists or BSCs are present in all needed			
settings.			



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.		
Chapter 3: Safeguards 3.1.2 <i>Team</i>		
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:		
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.		
The state of the s		

	T		
Tag # 1A08.3 Administrative Case File:	Condition of Participation Level Deficiency		
Individual Service Plan / ISP Components			
NMAC 7.26.5 SERVICE PLANS FOR	After an analysis of the evidence, it has been	Provider:	
INDIVIDUALS WITH DEVELOPMENTAL	determined there is a significant potential for a	State your Plan of Correction for the	
DISABILITIES LIVING IN THE COMMUNITY.	negative outcome to occur.	deficiencies cited in this tag here (How is the	
		deficiency going to be corrected? This can be	
NMAC 7.26.5.12 DEVELOPMENT OF THE	Based on record review, the Agency did not	specific to each deficiency cited or if possible, an	
INDIVIDUAL SERVICE PLAN (ISP) -	maintain a complete and confidential case file	overall correction?): →	
PARTICIPATION IN AND SCHEDULING OF	at the administrative office for 7 of 9		
INTERDISCIPLINARY TEAM MEETINGS.	individuals.		
NMAC 7.26.5.14 DEVELOPMENT OF THE	Review of the Agency administrative individual		
INDIVIDUAL SERVICE PLAN (ISP) -	case files revealed the following items were not		
CONTENT OF INDIVIDUAL SERVICE	found, incomplete, and/or not current:		
PLANS.			
	Addendum A:	Provider:	
Developmental Disabilities (DD) Waiver	• Not Found (2, 6, 7, 9, 10, 11)	Enter your ongoing Quality	
Service Standards 2/26/2018; Re-Issue:	140t1 outla (2, 0, 7, 0, 10, 11)	Assurance/Quality Improvement	
12/28/2018; Eff 1/1/2019	ISP Teaching and Support Strategies:	processes as it related to this tag number	
Chapter 6 Individual Service Plan: The	lor reacting and oupport offacegies.	here (What is going to be done? How many	
CMS requires a person-centered service plan	Individual #5:	individuals is this going to affect? How often will	
for every person receiving HCBS. The DD	TSS not found for the following Live Outcome	this be completed? Who is responsible? What	
Waiver's person-centered service plan is the	Statement / Action Steps:	steps will be taken if issues are found?): \rightarrow	
ISP.	"will help with preparing meals."		
101 .	wiii neip with preparing meals.		
6.5.2 ISP Revisions: The ISP is a dynamic	TSS not found for the following Work / Learn		
document that changes with the person's	Outcome Statement / Action Steps:		
desires, circumstances, and need. IDT	l •		
members must collaborate and request an IDT	"will choose and participate in leisure activities."		
meeting from the CM when a need to modify	activities.		
the ISP arises. The CM convenes the IDT	TOO was farmed familia a fall and an Francisco		
within ten days of receipt of any reasonable	TSS not found for the following Fun /		
request to convene the team, either in person	Relationships Outcome Statement / Action		
or through teleconference.	Steps:		
or unough teleconierence.	"will research locations to attend."		
6.6 DDSD ISP Template: The ISP must be	, , , , , , , , , , , , , , , , , , , ,		
written according to templates provided by the	"will attend venues of virtual locations."		
DDSD. Both children and adults have			
designated ISP templates. The ISP template	Individual #9:		
includes Vision Statements, Desired	TSS not found for the following Fun /		
	Relationships Outcome Statement / Action		
Outcomes, a meeting participant signature	Steps:		
page, an Addendum A (i.e., an			
acknowledgement of receipt of specific			

information) and other elements depending on the age of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use in order to better demonstrate required elements of the PCP process and ISP development. The ISP is completed by the CM with the IDT input and must be completed according to the following requirements: 1. DD Waiver Provider Agencies should not recommend service type, frequency, and amount (except for required case management services) on an individual budget prior to the Vision Statement and Desired Outcomes being developed. 2. The person does not require IDT agreement/approval regarding his/her dreams, aspirations, and desired long-term outcomes. 3. When there is disagreement, the IDT is required to plan and resolve conflicts in a manner that promotes health, safety, and quality of life through consensus. Consensus means a state of general agreement that allows members to support the proposal, at least on a trial basis. 4. A signature page and/or documentation of participation by phone must be completed. 5. The CM must review a current Addendum A and DHI ANE letter with the person and Court appointed guardian or parents of a minor, if applicable.	 "will find and plan to attend the church that is in the mountains he can attend." "will attend the church." 	
6.6.3 Additional Requirements for Adults: Because children have access to other funding sources, a larger array of services are available to adults than to children through the DD Waiver. (See Chapter 7: Available Services and Individual Budget Development). The ISP Template for adults is also more		
extensive including Action Plans Teaching		

extensive, including Action Plans, Teaching

and Support Strategies (TSS), Written Direct Support Instructions (WDSI), and Individual Specific Training (IST) requirements.		
6.6.3.1. Action Plan: Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes. Multiple service types may be included in the Action Plan under a single Desired Outcome. Multiple Provider Agencies can and should be contributing to Action Plans toward each Desired Outcome. 1. Action Plans include actions the person will take; not just actions the staff will take. 2. Action Plans delineate which activities will be completed within one year. 3. Action Plans are completed through IDT consensus during the ISP meeting. 4. Action Plans must indicate under "Responsible Party" which DSP or service provider (i.e., Family Living, CCS, etc.) are responsible for carrying out the Action Step.		
6.6.3.2 Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI): After the ISP meeting, IDT members conduct a task analysis and assessments necessary to create effective TSS and WDSI to support those Action Plans that require this extra detail. All TSS and WDSI should support the person in achieving his/her Vision.		
6.6.3.3 Individual Specific Training in the ISP: The CM, with input from each DD Waiver Provider Agency at the annual ISP meeting, completes the IST requirements section of the ISP form listing all training needs specific to the individual. Provider Agencies bring their proposed IST to the annual meeting. The IDT must reach a consensus about who needs to be trained, at what level (awareness,		

knowledge or skill), and within what timeframe.		
(See Chapter 17.10 Individual-Specific		
Training for more information about IST.)		
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.		

Tag # 1A08.1 Administrative and	Standard Level Deficiency		
Residential Case File: Progress Notes			
Developmental Disabilities (DD) Waiver	Based on record review, the Agency did not	Provider:	
Service Standards 2/26/2018; Re-Issue:	maintain progress notes and other service	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	delivery documentation for 7 of 18 Individuals.	deficiencies cited in this tag here (How is the	
Chapter 20: Provider Documentation and	,	deficiency going to be corrected? This can be	
Client Records 20.2 Client Records	Review of the Agency individual case files	specific to each deficiency cited or if possible an	
Requirements: All DD Waiver Provider	revealed the following items were not found:	overall correction?): \rightarrow	
Agencies are required to create and maintain			
individual client records. The contents of client	Administrative Case File:		
records vary depending on the unique needs of			
the person receiving services and the resultant	Supported Living Progress Notes/Daily		
information produced. The extent of	Contact Logs:		
documentation required for individual client	 Individual #1 – None found for 9/29 – 30, 		
records per service type depends on the	2021.		
location of the file, the type of service being		Provider:	
provided, and the information necessary.	 Individual #7 – None found for 10/28/2021. 	Enter your ongoing Quality	
DD Waiver Provider Agencies are required to	1110110101010101010101010101010101010101	Assurance/Quality Improvement	
adhere to the following:	 Individual #9 – None found for 11/5, 13, 14, 	processes as it related to this tag number	
1. Client records must contain all documents	27, 28, 30 2021.	here (What is going to be done? How many	
essential to the service being provided and	27, 20, 00 2021.	individuals is this going to affect? How often will	
essential to ensuring the health and safety of	 Individual #10 – None found for 11/26 – 28, 	this be completed? Who is responsible? What steps will be taken if issues are found?): →	
the person during the provision of the service.	2021.	steps will be taken it issues are found?): →	
2. Provider Agencies must have readily	2021.		
accessible records in home and community	 Individual #12 – None found for 9/4, 16 – 		
settings in paper or electronic form. Secure	20, 23 – 25, 2021.		
access to electronic records through the	20, 20 20, 2021.		
Therap web-based system using computers or	Customized Community Services		
mobile devices is acceptable.	Notes/Daily Contact Logs:		
3. Provider Agencies are responsible for	 Individual #1 - None found for 9/12 – 15, 		
ensuring that all plans created by nurses, RDs,	2021.		
therapists or BSCs are present in all needed	2021.		
settings.	 Individual #6 - None found for 9/27 – 30 and 		
4. Provider Agencies must maintain records	10/1, 2021.		
of all documents produced by agency	10/1, 2021.		
personnel or contractors on behalf of each	Community Integrated Employment		
person, including any routine notes or data,	Services Progress Notes/Daily Contact		
annual assessments, semi-annual reports,	Logs:		
evidence of training provided/received,	Individual #7 - None found for 9/1; 10/6; and		
progress notes, and any other interactions for	11/3, 2021.		
which billing is generated.	1 1/0, 2021.		
5. Each Provider Agency is responsible for			
maintaining the daily or other contact notes			

documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.	 Individual #16 - None found for 9/3; 10/7; and 11/3, 2021. Residential Case File: Supported Living Progress Notes/Daily Contact Logs: Individual #1 - None found for 1/1 - 2, 2022. (Date of home visit: 1/4/2022) Individual #9 - None found for 1/1 - 3, 2022. (Date of home visit: 1/4/2022) 		
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Tag # 1A32 Administrative Case File:	Condition of Participation Level Deficiency		
Individual Service Plan Implementation			
NMAC 7.26.5.16.C and D Development of	After an analysis of the evidence, it has been	Provider:	
the ISP. Implementation of the ISP. The ISP		State your Plan of Correction for the	
shall be implemented according to the		deficiencies cited in this tag here (How is the	
timelines determined by the IDT and as		deficiency going to be corrected? This can be	
specified in the ISP for each stated desired	Based on administrative record review, the	specific to each deficiency cited or if possible an	
outcomes and action plan.	Agency did not implement the ISP according to	overall correction?): \rightarrow	
	the timelines determined by the IDT and as		
C. The IDT shall review and discuss	specified in the ISP for each stated desired		
information and recommendations with the	outcomes and action plan for 5 of 9 individuals.		
individual, with the goal of supporting the			
individual in attaining desired outcomes. The	As indicated by Individuals ISP the following		
IDT develops an ISP based upon the	was found with regards to the implementation		
individual's personal vision statement,	of ISP Outcomes:		
strengths, needs, interests and preferences.		Provider:	
The ISP is a dynamic document, revised	Supported Living Data Collection/Data	Enter your ongoing Quality	
periodically, as needed, and amended to	Tracking/Progress with regards to ISP	Assurance/Quality Improvement	
reflect progress towards personal goals and	Outcomes:	processes as it related to this tag number	
achievements consistent with the individual's		here (What is going to be done? How many	
future vision. This regulation is consistent with	Individual #5	individuals is this going to affect? How often will this be completed? Who is responsible? What	
standards established for individual plan	None found regarding: Fun Outcome/Action	steps will be taken if issues are found?): →	
development as set forth by the commission on	Step: "will attend venues of virtual	steps will be taken it issues are round:)	
the accreditation of rehabilitation facilities	locations" for 11/2021. Action step is to be		
(CARF) and/or other program accreditation	completed 3 times per month.		
approved and adopted by the developmental			
disabilities division and the department of	Customized Community Supports Data		
health. It is the policy of the developmental	Collection / Data Tracking/Progress with		
disabilities division (DDD), that to the extent	regards to ISP Outcomes:		
permitted by funding, each individual receive			
supports and services that will assist and	Individual #1		
encourage independence and productivity in	None found regarding: Fun Outcome/Action		
the community and attempt to prevent	Step: "will choose an outing of his choice"		
regression or loss of current capabilities.	for 9/2021 - 11/2021. Action step is to be		
Services and supports include specialized	completed 3 times per week.		
and/or generic services, training, education	·		
and/or treatment as determined by the IDT and	Individual #5		
documented in the ISP.	None found regarding: Fun Outcome/Action		
	Step: "will attend venues of virtual		
D. The intent is to provide choice and obtain	locations" for 11/2021. Action step is to be		
opportunities for individuals to live, work and	completed 3 times per month.		
play with full participation in their communities.			
The following principles provide direction and			

purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019

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

Chapter 20: Provider Documentation and Client Records 20.2 Client Records

Requirements: All 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:

Client records must contain all documents

Community Integrated Employment Services Data Collection / Data Tracking/Progress with regards to ISP Outcomes:

Individual #2

- According to the Work/Learn Outcome, Action Step for "...will research employment" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2021. (Note: Document maintained by the provider was blank.)
- According to the Work/Learn Outcome, Action Step for "...will apply" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2021. (Note: Document maintained by the provider was blank.)

Individual #7

 None found regarding: Work/Learn Outcome/Action Step: "...will work her scheduled shifts" for 9/2021 – 11/2021. Action step is to be completed 1 time per week.

Individual #11

None found regarding: Work/Learn
 Outcome/Action Step: "...will perform
 assigned office tasks to completion during a
 work shift" for 9/2021 – 11/2021. Action step
 is to be completed 1-2 times per week.

essential to the service being provided and		
essential to ensuring the health and safety of		
the person during the provision of the service.		
Provider Agencies must have readily		
accessible records in home and community		
settings in paper or electronic form. Secure		
access to electronic records through the		
Therap web-based system using computers or		
mobile devices is acceptable.		
3. Provider Agencies are responsible for		
ensuring that all plans created by nurses, RDs,		
therapists or BSCs are present in all needed		
settings.		
4. Provider Agencies must maintain records		
of all documents produced by agency		
personnel or contractors on behalf of each		
person, including any routine notes or data,		
annual assessments, semi-annual reports,		
evidence of training provided/received,		
progress notes, and any other interactions for		
which billing is generated.		
5. Each Provider Agency is responsible for		
maintaining the daily or other contact notes		
documenting the nature and frequency of		
service delivery, as well as data tracking only		
for the services provided by their agency.		
6. The current Client File Matrix found in		
Appendix A Client File Matrix details the		
minimum requirements for records to be		
stored in agency office files, the delivery site,		
or with DSP while providing services in the		
community.		
7. All records pertaining to JCMs must be		
retained permanently and must be made		
available to DDSD upon request, upon the		
termination or expiration of a provider		
agreement, or upon provider withdrawal from		
services.		

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not	Standard Level Deficiency		
Completed at Frequency)			
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.	Based on administrative record review and interview, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 5 of 9 individuals.	Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible, an overall correction?): →	
C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities.	As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: Supported Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes: Individual #1 • According to the Live Outcome, Action Step for "will go through a list of chores that him and staff come up with to work on for the week" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 and 11/2021. Individual #2 • According to the Live Outcome, Action Step for "will research classes" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 – 11/2021. • According to the Live Outcome, Action Step for "will choose between a meditation or physical class that she would like to attend" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 – 11/2021.	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →	

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

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018: Eff 1/1/2019

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

Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements: All 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:

- According to the Live Outcome, Action Step for "...will attend the class" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 and 11/2021.
- According to the Fun Outcome, Action Step for "...will research art and craft events (virtually)" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 and 11/2021.
- According to the Fun Outcome, Action Step for "...will attend (virtually)" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 and 11/2021.

Individual #5

- According to the Fun Outcome, Action Step for "...will research locations to attend." is to be completed 3 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 and 11/2021.
- According to the Fun Outcome, Action Step for "...will attend venues of virtual locations." is to be completed 3 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021.

Individual #6

 According to the Live Outcome, Action Step for "...will water plants 2x weekly" is to be completed 2 times per week. Evidence

- 8. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.
- 9. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable.
- 10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.
- 11. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.
- 12. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.
- 13. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.
- 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.

found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 – 11/2021.

Individual #7

 According to the Live Outcome, Action Step for "...will choose and plan a physical activity that she would like to do" is to be completed 5 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 – 11/2021.

Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #1

- According to the Work/Learn Outcome; Action Step for "...will complete sustained walking for 20 to 30 minutes" is to be completed 2 times per Week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 and 11/2021.
- According to the Work/Learn Outcome; Action Step for "...will track his steps" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 and 11/2021.

Individual #2

 According to the Work/Learn Outcome, Action Step for "...will research employment" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 – 11/2021.

Individual #6

 According to the Work/Learn Outcome, Action Step for "will put his picture in a photo album 1 time weekly" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 – 11/2021. 	
Community Integrated Employment Services Data Collection/Data Tracking / Progress with regards to ISP Outcomes:	
Individual #2 • According to the Work/Learn Outcome, Action Step for "will research employment" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 – 10/2021.	
 According to the Work/Learn Outcome, Action Step for "will apply" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2021 – 10/2021. 	
 Individual #7 According to the Fun/Relationships Outcome; Action Step for "will learn to use her iPad" is to be completed 3 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2021. 	

Tag # LS14 Residential Service Delivery	Condition of Participation Level Deficiency		
Site Case File (ISP and Healthcare	Condition of Farticipation Level Denciency		
Requirements)			
Developmental Disabilities (DD) Waiver	After an analysis of the evidence, it has been	Provider:	
Service Standards 2/26/2018; Re-Issue:	determined there is a significant potential for a	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	negative outcome to occur.	deficiencies cited in this tag here (How is the	
Chapter 20: Provider Documentation and		deficiency going to be corrected? This can be	
Client Records: 20.2 Client Records	Based on record review, the Agency did not	specific to each deficiency cited or if possible, an	
Requirements: All DD Waiver Provider	maintain a complete and confidential case file	overall correction?): \rightarrow	
Agencies are required to create and maintain	in the residence for 7 of 9 Individuals receiving		
individual client records. The contents of client	Living Care Arrangements.		
records vary depending on the unique needs			
of the person receiving services and the	Review of the residential individual case files		
resultant information produced. The extent of	revealed the following items were not found,		
documentation required for individual client	incomplete, and/or not current:		
records per service type depends on the		Provide Land	
location of the file, the type of service being	ISP Teaching and Support Strategies:	Provider:	
provided, and the information necessary.	Individual #1:	Enter your ongoing Quality	
DD Waiver Provider Agencies are required to	TSS not found for the following Live Outcome	Assurance/Quality Improvement	
adhere to the following:	Statement / Action Steps:	processes as it related to this tag number	
Client records must contain all documents	"will go through a list of chores that him	here (What is going to be done? How many individuals is this going to affect? How often will	
essential to the service being provided and	and staff come up with to work on for the	this be completed? Who is responsible? What	
essential to ensuring the health and safety of	week."	steps will be taken if issues are found?): →	
the person during the provision of the service.			
Provider Agencies must have readily	"will, with visual cues, be prompted to		
accessible records in home and community	clean his apartment with decreasing		
settings in paper or electronic form. Secure	prompts."		
access to electronic records through the			
Therap web-based system using computers or	"will clean his apartment based upon his		
mobile devices is acceptable.	pictures of how his apartment is supposed		
3. Provider Agencies are responsible for	to look like."		
ensuring that all plans created by nurses,			
RDs, therapists or BSCs are present in all	Individual #2		
needed settings.	TSS not found for the following Live Outcome		
4. Provider Agencies must maintain records of	Statement / Action Steps:		
all documents produced by agency personnel	"will research classes."		
or contractors on behalf of each person,			
including any routine notes or data, annual	Individual #5		
assessments, semi-annual reports, evidence	TSS not found for the following Live Outcome		
of training provided/received, progress notes,	Statement / Action Steps:		
and any other interactions for which billing is	"will help with preparing meals."		
generated.			
5. Each Provider Agency is responsible for			

maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.

6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.

7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.

20.5.3 Health Passport and Physician Consultation Form: All Primary and Secondary 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:

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

TSS not found for the following Work / Learn Outcome Statement / Action Steps:

"...will choose and participate in leisure activities."

TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:

• "...will research locations to attend."

Individual #6

TSS not found for the following Live Outcome Statement / Action Steps:

- "...will purchase and plant 3 different vegetable plants."
- "...will water plants."
- "Harvest vegetables."

Individual #9

TSS not found for the following Live Outcome Statement / Action Steps:

- "...will with decreased prompts, clean his room thoroughly."
- "...will do a light / maintenance bedroom cleaning 2 times per month as well."

Individual #10

TSS not found for the following Live Outcome Statement / Action Steps:

- "I will research courses available."
- "I will register for the course."
- "I will attend the class as required."

Healthcare Passport:

- Not Found (#6)
- Not Current (#2, 5, 10, 11)

in the IDF.

Chapter 13: Nursing Services: 13.2.9 Healthcare Plans (HCP):

- 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 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 lifethreatening situation.

Comprehensive Aspiration Risk Management Plan:

Not Found (#5)

Health Care Plans:

- Body Mass Index (#1, 2)
- MRSA (#1)
- Sleep Apnea (#9)

Medical Emergency Response Plans:

- Body Mass Index (#1)
- Falls (#6)
- MRSA (#1)
- Respiratory / Asthma (#9)
- Seizures (#5)
- Sleep Apnea (#9)
- Urinary (#6)

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
		to assure adherence to waiver requirements. The	
		nce with State requirements and the approved wain	<i>er.</i>
Tag # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency	Para Mara	
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 Chapter 13: Nursing Services 13.2.11 Training and Implementation of Plans: 1. RNs and LPNs are required to provide Individual Specific Training (IST) regarding HCPs and MERPs. 2. The agency nurse is required to deliver and document training for DSP/DSS regarding the healthcare interventions/strategies and MERPs that the DSP are responsible to implement, clearly indicating level of competency achieved	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 7 of 10 Direct Support Personnel. When DSP were asked, if the Individual had a Positive Behavioral Supports Plan (PBSP), have you been trained on the PBSP and what does the plan cover, the following was reported:	Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →	
by each trainee as described in Chapter 17.10 Individual-Specific Training. Chapter 17: Training Requirement 17.10 Individual-Specific Training: The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the	DSP #530 stated, "No, I really don't know." According to the Individual Specific Training Section of the ISP the Individual requires a Positive Behavioral Supports Plan. (Individual #8) When DSP were asked, if they received training on the Individual's Behavioral Crisis Intervention Plan (BCIP) and if so, what the plan covered, the following was	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →	
established DDSD training levels of awareness, knowledge, and skill. Reaching an awareness level may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a knowledge level may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee.	 PSP #530 stated, "No, I really don't know." According to the Individual Specific Training Section of the ISP the individual has Behavioral Crisis Intervention Plan. (Individual #8) DSP #531 stated, "She doesn't have a plan." According to the Individual Specific Training Section of the ISP the individual 	Motro - January 3 - 14, 2022	

Verbal or written recall or demonstration may verify this level of competence.

Reaching a skill level involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST

1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends.

requirements in accordance with the

person supported.

specifications described in the ISP of each

- 2. IST for therapy related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher.
- 3. The competency level of the training is based on the IST section of the ISP.
- 4. The person should be present for and involved in IST whenever possible.
- 5. Provider Agencies are responsible for

has Behavioral Crisis Intervention Plan. (Individual #8)

- DSP #536 stated, "I'm not really sure, they brought the paperwork to me yesterday." According to the Positive Behavioral Support Plan, the individual has Behavioral Crisis Intervention Plan. (Individual #2)
- DSP #561 stated, "I don't think so."
 According to the Positive Behavior Support
 Plan, the individual has Behavioral Crisis
 Intervention Plan. (Individual #5)

When DSP were asked, if the Individual had a Comprehensive Aspiration Risk Management Plan (CARMP) and where was it located, the following was reported:

DSP #530 stated, "I've never seen it, but I was trained on how to sit with her." As indicated by the Aspiration Risk Screening Tool, the individual has a Comprehensive Aspiration Risk Management Plan (CARMP). (Individual #7)

When DSP were asked, if the Individual's had Health Care Plans, where could they be located and if they had been trained, the following was reported:

- DSP #536 stated, "Just drinking to keep her hydrated." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index. (Individual #2)
- DSP #561 stated, "Yes. They should be in her book. They are missing from the home.
 So is the CARMP. I don't know what they are without them in front of me." As indicated by the Electronic Comprehensive

tracking of IST requirements.
6. Provider Agencies must arrange and
ensure that DSP's are trained on the contents
of the plans in accordance with timelines
indicated in the Individual-Specific Training
Requirements: Support Plans section of the
ISP and notify the plan authors when new DSP
are hired to arrange for trainings.
7. If a therapist, BSC, nurse, or other author of
a plan, healthcare or otherwise, chooses to
designate a trainer, that person is still
responsible for providing the curriculum to the
designated trainer. The author of the plan is
also responsible for ensuring the designated

trainer is verifying competency in alignment

with their curriculum, doing periodic quality

assurance checks with their designated trainer,

and re-certifying the designated trainer at least

annually and/or when there is a change to a

person's plan.

- Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index, Oral Hygiene, and Seizure Disorder. (Individual #5)
- DSP #530 stated, "I don't have that." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index, Asthma, and Sleep Apnea. (Individual #7)
- DSP #531 stated, "Health Care Plan let me check, no she doesn't have a Health Care Plan." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index, Asthma, and Sleep Apnea. (Individual #7)

When DSP were asked, if the Individual's had Medical Emergency Response Plans and where could they be located, the following was reported:

- DSP #511 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual has Medical Emergency Response Plans for Obstructive Sleep Apnea. (Individual #9)
- DSP #530 stated, "I'm going to say no." As Indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Aspiration and Asthma. (Individual #7)
- DSP #530 stated, "I believe so, but I haven't seen them." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency

Response Plans for Dehydration, Falls, and Seizures. (Individual #8) • DSP #531 stated, "She has asthma, we give her, her asthma spray and call the nurse." As Indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires Medical Emergency Response Plans for Aspiration. (Individual #7)	
DSP #561 stated, "Yes. They should be in her book. They are missing from the home. So is the CARMP. I don't know what they are without them in front of me." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Aspiration and Seizure Disorder. (Individual #5)	
When DSP were asked, if the Individual had any food and / or medication allergies that could be potentially life threatening, the following was reported:	
DSP #573 stated, "Red dye and the flu shot eggs" As indicated by Health Passport the individual is allergic to Morphine. (Individual #2)	
DSP #536 stated, "Not to my knowledge." As indicated by Health Passport the individual is allergic to Morphine. (Individual #2)	
DSP #511 stated, "That I'm aware of, no." As indicated by the Health Passport the individual is allergic to Bupropion, Chantix, and Wellbutrin. (Individual #9)	

When DSP were asked, if the Individual had Seizure Disorder, as well as a series of questions specific to the DSP's knowledge of the Seizure Disorder, the following was reported:	
DSP #507 stated, "No, I just want to keep him safe. No one has told me them because he hasn't had one with me." Per Electronic Comprehensive Health Assessment Tool residential staff are required to receive training on Seizure Disorder. (Individual #1)	
DSP #530 stated, "I believe so or is it I'm sorry not, I don't think so." As indicated by the Individual Specific Training section of the ISP DSP require training on Seizure Disorder. (Individual #8)	
When DSP were asked, what steps are you to take in the event of a medication error, the following was reported:	
SP #507 stated, "I would throw it away." (Individual #1) According to the Agency Policy and Procedure for Supported Living Disposal of Medications, "DSP are to Place the medication in a bag that can be sealed. Label the bag. Seal the bag and place it in the designated discontinued lock box and document on the Drug Destruction Log."	

Tag # 1A25.1 Caregiver Criminal History Screening	Condition of Participation Level Deficiency		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: A. General: The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants,	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation indicating Caregiver	Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →	
caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a	Criminal History Screening was completed as required for 5 of 79 Agency Personnel. The following Agency Personnel Files contained no evidence of Caregiver		
nationwide and statewide criminal history screening, as described in Subsections D, E	Criminal History Screenings:		
and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care	Direct Support Personnel (DSP): • #543 – Date of hire 3/20/2020.	Provider: Enter your ongoing Quality Assurance/Quality Improvement	
providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978	The following Agency Personnel Files contained a letter of disqualification from the Caregiver Criminal History Screening Program:	processes as it related to this tag number here (What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →	
(Amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to	Direct Support Personnel (DSP): • #509 – Date of hire 12/20/2021.		
the care provider] to impose appropriate administrative sanctions and penalties.	• #511 – Date of hire 12/14/2021.		
B. Exception: A caregiver or hospital caregiver applying for employment or	• #516 – Date of hire 8/20/2020.		
contracting services with a care provider within twelve (12) months of the caregiver's or hospital caregiver's most recent nationwide	• #526 – Date of hire 12/20/2021.		
criminal history screening which list no			
disqualifying convictions shall only apply for a statewide criminal history screening upon offer			
of employment or at the time of entering into a			
contractual relationship with the care provider. At the discretion of the care provider a			
nationwide criminal history screening,			
additional to the required statewide criminal history screening, may be requested.			

C. Conditional Employment: Applicants,		
caregivers, and hospital caregivers who have		
submitted all completed documents and paid		
all applicable fees for a nationwide and		
statewide criminal history screening may be		
deemed to have conditional supervised		
employment pending receipt of written notice		
given by the department as to whether the		
applicant, caregiver or hospital caregiver has a		
disqualifying conviction.		
F. Timely Submission: Care providers shall		
submit all fees and pertinent application		
information for all individuals who meet the		
definition of an applicant, caregiver or hospital		
caregiver as described in Subsections B, D		
and K of 7.1.9.7 NMAC, no later than twenty		
(20) calendar days from the first day of		
employment or effective date of a contractual		
relationship with the care provider.		
G. Maintenance of Records: Care providers		
shall maintain documentation relating to all		
employees and contractors evidencing		
compliance with the act and these rules.		
(1) During the term of employment, care		
providers shall maintain evidence of each		
applicant, caregiver or hospital caregiver's		
clearance, pending reconsideration, or		
disqualification.		
(2) Care providers shall maintain documented		
evidence showing the basis for any		
determination by the care provider that an		
employee or contractor performs job functions		
that do not fall within the scope of the		
requirement for nationwide or statewide		
criminal history screening. A memorandum in		
an employee's file stating "This employee does		
not provide direct care or have routine		
unsupervised physical or financial access to		
care recipients served by [name of care		
provider]," together with the employee's job		
description, shall suffice for record keeping		
purposes.	l ·	

NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.		
NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: A. homicide. B. trafficking, or trafficking in controlled substances. C. kidnapping, false imprisonment, aggravated assault or aggravated battery. D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses. E. crimes involving adult abuse, neglect or financial exploitation. F. crimes involving child abuse or neglect. G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.		

Tag # 1A37 Individual Specific Training	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver	After an analysis of the evidence, it has been	Provider:	
Service Standards 2/26/2018; Re-Issue:	determined there is a significant potential for a	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	negative outcome to occur.	deficiencies cited in this tag here (How is the	
Chapter 17: Training Requirements: The		deficiency going to be corrected? This can be	
purpose of this chapter is to outline	Based on record review, the Agency did not	specific to each deficiency cited or if possible an	
requirements for completing, reporting and	ensure that Individual Specific Training	overall correction?): \rightarrow	
documenting DDSD training requirements for	requirements were met for 31 of 79 Agency		
DD Waiver Provider Agencies as well as	Personnel.		
requirements for certified trainers or mentors			
of DDSD Core curriculum training.	Review of personnel records found no		
17.1 Training Requirements for Direct	evidence of the following:		
Support Personnel and Direct Support			
Supervisors: Direct Support Personnel	Direct Support Personnel (DSP):	Provide to a	
(DSP) and Direct Support Supervisors (DSS)		Provider:	
include staff and contractors from agencies	Individual Specific Training:	Enter your ongoing Quality	
providing the following services: Supported	 None found: #505, 507, 513, 522, 524, 	Assurance/Quality Improvement	
Living, Family Living, CIHS, IMLS, CCS, CIE	539, 564, 565, 567	processes as it related to this tag number	
and Crisis Supports.		here (What is going to be done? How many individuals is this going to affect? How often will	
 DSP/DSS must successfully: 	 Individual #13 (#510, 523, 552) 	this be completed? Who is responsible? What	
a. Complete IST requirements in accordance	, ,	steps will be taken if issues are found?): →	
with the specifications described in the ISP	 Individual #18 (#500, 515, 534, 542, 548, 	otope viii so taken n loodee are realia. /i	
of each person supported and as outlined	554, 556, 560, 566, 577)		
in 17.10 Individual-Specific Training below.			
 b. Complete training on DOH-approved ANE 	 Individual #19 (#502, 517, 529, 530, 531, 		
reporting procedures in accordance with	541, 566)		
NMAC 7.1.14	. ,		
c. Complete training in universal precautions.	 Individual #20 (#500, 504, 515, 534, 542, 		
The training materials shall meet	548, 554, 556, 560, 566, 573, 577)		
Occupational Safety and Health	,		
Administration (OSHA) requirements	Health Care Plan Training:		
d. Complete and maintain certification in First	 Individual #18 (#500, 556) 		
Aid and CPR. The training materials shall			
meet OSHA requirements/guidelines.	 Individual #19 (#502, 516, 517, 529, 530, 		
e. Complete relevant training in accordance	531, 541, 566)		
with OSHA requirements (if job involves	331, 311, 333)		
exposure to hazardous chemicals).	 Individual #20 (#500, 504, 515, 534, 542, 		
f. Become certified in a DDSD-approved	548, 554, 556, 560, 566, 577)		
system of crisis prevention and	3 10, 00 1, 000, 000, 0117		
intervention (e.g., MANDT, Handle with	Medical Emergency Response Plan		
Care, CPI) before using EPR. Agency DSP	Training:		
and DSS shall maintain certification in a	Tranmig.		
DDSD-approved system if any person they			

- support has a BCIP that includes the use of EPR.
- g. Complete and maintain certification in a DDSD-approved medication course if required to assist with medication delivery.
- h. Complete training regarding the HIPAA.
- 2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings and be on shift with a DSP who has completed the relevant IST.

17.10 Individual-Specific Training: The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an awareness level may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a knowledge level may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a skill level involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the

- Individual #18 (#500, 515, 534, 542, 548, 554, 556, 560, 566, 577)
- Individual #19 (#502, 517, 529, 530, 531, 541, 566)
- Individual #20 (#500, 504, 515, 534, 542, 548, 554, 556, 560, 566, 577)
- Comprehensive Aspiration Risk Management Plan Training:
 - Individual #18 (#500, 504, 515, 534, 542, 548, 554, 556, 560, 566, 577)
 - Individual #19 (#502, 516, 517, 529, 530, 531, 541, 566)
 - Individual #20 (#534, 554)

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

designate a trainer, that person is still

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

Tag # 1A43.1 General Events Reporting:	Standard Level Deficiency		
Individual Reporting			
Developmental Disabilities (DD) Waiver	Based on record review, the Agency did not	Provider:	
Service Standards 2/26/2018; Re-Issue:	follow the General Events Reporting	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	requirements as indicated by the policy for 6 of	deficiencies cited in this tag here (How is the	
Chapter 19: Provider Reporting	9 individuals.	deficiency going to be corrected? This can be	
Requirements: 19.2 General Events		specific to each deficiency cited or if possible an	
Reporting (GER): The purpose of General	The following General Events Reporting	overall correction?): \rightarrow	
Events Reporting (GER) is to report, track and	records contained evidence that indicated		
analyze events, which pose a risk to adults in	the General Events Report was not entered		
the DD Waiver program, but do not meet	and / or approved within the required		
criteria for ANE or other reportable incidents as	timeframe:		
defined by the IMB. Analysis of GER is			
intended to identify emerging patterns so that	Individual #1		
preventative action can be taken at the	General Events Report (GER) indicates on		
individual, Provider Agency, regional and	5/29/2021 the Individual was seen for an	Provider:	
statewide level. On a quarterly and annual	emergency psychiatric evaluation.	Enter your ongoing Quality	
basis, DDSD analyzes GER data at the	(Emergency Medicine). GER was approved	Assurance/Quality Improvement	
provider, regional and statewide levels to	6/4/2021.	processes as it related to this tag number	
identify any patterns that warrant intervention.		here (What is going to be done? How many	
Provider Agency use of GER in Therap is	General Events Report (GER) indicates on	individuals is this going to affect? How often will this be completed? Who is responsible? What	
required as follows:	7/26/2021 the Individual was hospitalized.	steps will be taken if issues are found?): →	
DD Waiver Provider Agencies	(Out of Home Placement). GER was	steps will be taken it issues are round?). →	
approved to provide Customized In-	approved 7/31/2021.		
Home Supports, Family Living, IMLS,			
Supported Living, Customized	General Events Report (GER) indicates on		
Community Supports, Community	9/15/2021 the Individual received a Covid -		
Integrated Employment, Adult Nursing	19 vaccine. (Covid -19). GER was approved		
and Case Management must use GER in	9/28/2021.		
the Therap system.			
2. DD Waiver Provider Agencies	General Events Report (GER) indicates on		
referenced above are responsible for entering	11/4/2021 required stitches after cutting		
specified information into the GER section of	himself. (Emergency Medicine). GER was		
the secure website operated under contract by	approved 1/12/2022.		
Therap according to the GER Reporting	3FF		
Requirements in Appendix B GER	Individual #2		
Requirements.	General Events Report (GER) indicates on		
3. At the Provider Agency's discretion	10/22/2021 the Individual fell. (Injury). GER		
additional events, which are not required by	was approved 1/12/2022.		
DDSD, may also be tracked within the GER			
section of Therap.	General Events Report (GER) indicates on		
4. GER does not replace a Provider	11/6/2021 the Individual required the use of		
Agency's obligations to report ANE or other			

reportable incidents as described in Chapter 18: Incident Management System.

5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities.

Appendix B GER Requirements: DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting:

- 1. Effective immediately, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau.
- 2. No alternative methods for reporting are permitted.

The following events need to be reported in the Therap GER:

- Emergency Room/Urgent Care/Emergency Medical Services
- Falls Without Injury
- Injury (including Falls, Choking, Skin Breakdown and Infection)
- Law Enforcement Use
- Medication Errors
- Medication Documentation Errors
- Missing Person/Elopement
- Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission
- PRN Psychotropic Medication
- Restraint Related to Behavior
- Suicide Attempt or Threat

Entry Guidance: Provider Agencies must complete the following sections of the GER with detailed information: profile information, event information, other event information,

- Law Enforcement (Law Enforcement). GER was approved 11/11/2021.
- General Events Report (GER) indicates on 11/26/2021 the Individual received a PRN Psychotropic Medication (PRN Psychotropic Medication). GER was approved 1/12/2022.
- General Events Report (GER) indicates on 12/1/2021 there were missing entries on the Medication Administration Record. (Medication Error). GER was approved 1/12/2022.
- General Events Report (GER) indicates on 12/2/2021 there were missing entries on the Medication Administration Record. (Medication Error). GER was approved 1/12/2022.

Individual #5

- General Events Report (GER) indicates on 3/20/2021 the Individual was ill and went to Urgent Care. (Emergency Medicine). GER was approved 3/30/2021.
- General Events Report (GER) indicates on 4/3/2021 the Individual required the use of Law Enforcement (Law Enforcement). GER was approved 4/15/2021.

Individual #6

- General Events Report (GER) indicates on 3/4/2021 the Individual had a fall and went to the emergency room. (Emergency Medicine). GER was approved 3/9/2021.
- General Events Report (GER) indicates on 5/27/2021 the Individual had a fall and went to the emergency room. (Emergency Medicine). GER was approved 6/1/2021.

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

 General Events Report (GER) indicates on 12/2/2021 the Individual received a COVID Vaccine. (Covid-19). GER was approved 12/7/2021.

Individual #10

 General Events Report (GER) indicates on 1/23/2021 there were missing entries on the Medication Administration Record. (Medication Error). GER was approved 5/11/2021.

Individual #11

- General Events Report (GER) indicates on 3/4/2021 the Individual went to Urgent Care for Conjunctivitis. (Emergency Medicine). GER was approved 3/9/2021.
- General Events Report (GER) indicates on 5/16/2021 the Individual received a PRN Psychotropic Medication (PRN Psychotropic Medication). GER was approved 5/21/2021.
- General Events Report (GER) indicates on 7/19/2021 the Individual required the use of Law Enforcement. (Law Enforcement). GER was approved 7/26/2021.
- General Events Report (GER) indicates on 8/14/2021 the Individual received a PRN Psychotropic Medication (PRN Psychotropic Medication). GER was approved 8/18/2021.
- General Events Report (GER) indicates on 1/4/2022 the Individual received a PRN Psychotropic Medication (PRN Psychotropic Medication). GER was approved 1/7/2022.

The following events were not reported in the General Events Reporting System as required by policy:

 Individual #2 Documentation reviewed indicates that on 12/1/2021 the Individual's Medication Administration Records contained a missing entry for Olanzapine 20mg tablet (8PM) (Medication Error). No GER was found. 	
 Documentation reviewed indicates that on 12/2/2021 the Individual's Medication Administration Records contained a missing entry for Fluticasone Prop 50mcg (8 AM) (Medication Error). No GER was found. 	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Health and Welfare - The st	ate, on an ongoing basis, identifies, addresses and	seeks to prevent occurrences of abuse, neglect a	nd
exploitation. Individuals shall be afforded their l	pasic human rights. The provider supports individu	als to access needed healthcare services in a time	ely manner.
Tag # 1A08.2 Administrative Case File:	Condition of Participation Level Deficiency		
Healthcare Requirements & Follow-up			
Developmental Disabilities (DD) Waiver	After an analysis of the evidence, it has been	Provider:	
Service Standards 2/26/2018; Re-Issue:	determined there is a significant potential for a	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	negative outcome to occur.	deficiencies cited in this tag here (How is the	
Chapter 3 Safeguards: 3.1.1 Decision		deficiency going to be corrected? This can be	
Consultation Process (DCP): Health	Based on record review, the Agency did not	specific to each deficiency cited or if possible an	
decisions are the sole domain of waiver	provide documentation of annual physical	overall correction?): \rightarrow	
participants, their guardians or healthcare	examinations and/or other examinations as		
decision makers. Participants and their	specified by a licensed physician for 3 of 9		
healthcare decision makers can confidently	individuals receiving Living Care Arrangements		
make decisions that are compatible with their	and Community Inclusion.		
personal and cultural values. Provider	,		
Agencies are required to support the informed	Review of the administrative individual case		
decision making of waiver participants by	files revealed the following items were not		
supporting access to medical consultation,	found, incomplete, and/or not current:	Provider:	
information, and other available resources	, , ,	Enter your ongoing Quality	
according to the following:	Living Care Arrangements / Community	Assurance/Quality Improvement	
1. The DCP is used when a person or	Inclusion (Individuals Receiving Multiple	processes as it related to this tag number	
his/her guardian/healthcare decision maker	Services):	here (What is going to be done? How many	
has concerns, needs more information about	,	individuals is this going to affect? How often will	
health-related issues, or has decided not to	Annual Physical:	this be completed? Who is responsible? What	
follow all or part of an order, recommendation,	Not Found (#5, 7) (Note: Exam was	steps will be taken if issues are found?): \rightarrow	
or suggestion. This includes, but is not limited	scheduled for #5 for 4/22/2022 during the		
to:	on-site survey.)		
a. medical orders or recommendations from			
the Primary Care Practitioner, Specialists	Dental Exam:		
or other licensed medical or healthcare	Individual #5 - As indicated by DDW		
practitioners such as a Nurse Practitioner	Standards the Individual is to receive an		
(NP or CNP), Physician Assistant (PA) or	Annual Dental exam. No evidence of exam		
Dentist.	found. (Note: Exam was scheduled for		
b. clinical recommendations made by	1/18/2022 during the on-site survey.)		
registered/licensed clinicians who are	17 10/2022 daring the on the survey.)		
either members of the IDT or clinicians	Individual #6 - As indicated by DDW		
who have performed an evaluation such	Standards the Individual is to receive an		
as a video-fluoroscopy.	Annual Dental exam. No evidence of exam		
c. health related recommendations or	found.		
suggestions from oversight activities such	Touriu.		
as the Individual Quality Review (IQR) or			

- other DOH review or oversight activities; and
- d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.
- 2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting:
 - a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation.
 - b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation.
 - c. Providers support the person/guardian to make an informed decision.
 - d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.

Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client

Emergency Medicine:

 Individual #6 - As indicated by collateral documentation reviewed, exam was completed on 10/18/2021. Follow-up was to be completed as soon as possible. No evidence of follow-up found.

Podiatry:

 Individual #6 - As indicated by collateral documentation reviewed, exam was scheduled for 11/18/2021. Individual refused exam. No evidence of rescheduled appointment found or follow-up with the individual and / or guardian.

Psychology:

 Individual #6 - As indicated by collateral documentation reviewed, exam was completed on 9/20/2021. Follow-up was to be completed in 2 - 4 weeks. No evidence of follow-up found.

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:		
Client records must contain all documents		
essential to the service being provided and		
essential to ensuring the health and safety of		
the person during the provision of the service.		
Provider Agencies must have readily		
accessible records in home and community		
settings in paper or electronic form. Secure		
access to electronic records through the		
Therap web-based system using computers or		
mobile devices is acceptable.		
3. Provider Agencies are responsible for		
ensuring that all plans created by nurses,		
RDs, therapists or BSCs are present in all		
needed settings.		
4. Provider Agencies must maintain records		
of all documents produced by agency		
personnel or contractors on behalf of each		
person, including any routine notes or data,		
annual assessments, semi-annual reports,		
evidence of training provided/received,		
progress notes, and any other interactions for		
which billing is generated.		
5. Each Provider Agency is responsible for		
maintaining the daily or other contact notes		
documenting the nature and frequency of		
service delivery, as well as data tracking only		
for the services provided by their agency.		
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.	l l	

7. All records pertaining to JCMs must be

retained permanently and must be made			
available to DDSD upon request, upon the			
termination or expiration of a provider			
agreement, or upon provider withdrawal from			
services.			
20.5.3 Health Passport and Physician			
Consultation Form: All Primary and			
Secondary 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.			
Observation 40. I believe Osma Assessments			
Chapter 10: Living Care Arrangements			
(LCA) Living Supports-Supported Living:			
10.3.9.6.1 Monitoring and Supervision			
4. Ensure and document the following:			
a. The person has a Primary Care			
Practitioner.			
b. The person receives an annual			
physical examination and other examinations as recommended by a			
Primary Care Practitioner or			
specialist.			
c. The person receives			
annual dental check-ups			
and other check-ups as			
recommended by a			
licensed dentist.			
d. The person receives a hearing test as			
recommended by a licensed audiologist.			
e. The person receives eye			
examinations as			
	1	1	

recommended by a

licensed optometrist or ophthalmologist. 5. Agency activities occur as required for follow-up activities to medical appointments (e.g., treatment, visits to specialists, and changes in medication or daily routine). 10.3.10.1 Living Care Arrangements (LCA) Living Supports-IMLS: 10.3.10.2 General Requirements: 9. Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and		
annual dental checkup by a licensed dentist). Chapter 13 Nursing Services: 13.2.3 General Requirements: 1. Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information.		

Tag # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency	
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur.	Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the
Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR): A current	Medication Administration Records (MAR) were reviewed for the months of December	deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →
Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered.	2021 and January 2022. Based on record review, 6 of 9 individuals had	
Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or	Medication Administration Records (MAR), which contained missing medications entries and/or other errors:	
treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a	Individual #1 January 2022	Provider: Enter your ongoing Quality
MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for:	Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:	Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many
Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the	 Clonidine HCL 0.2mg (3 times daily) – Blank 1/4 (7:00 AM), 1/4 (4:00 PM) 	individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →
MAR in Therap but are not mandated to do so. 2. Continually communicating any	 Desmopressin Acetate 0.1mg (1 time daily) – Blank 1/1 – 4 (8:00 PM) 	
changes about medications and treatments between Provider Agencies to assure health and safety.	 Divalproex Sodium ER 500mh (1 time daily) – Blank 1/1 (8:00 PM) 	
7. Including the following on the MAR: a. The name of the person, a transcription of the physician's or	 Olanzapine 20mg (1 time daily) – Blank 1/1 (8:00 PM) 	
licensed health care provider's orders including the brand and generic names for all ordered routine and PRN	 Prazosin 2mg (2 times daily) – Blank 1/1 (5:00 PM and 8:00 PM) 	
medications or treatments, and the diagnoses for which the medications or treatments are prescribed.	Individual #2 December 2021 Medication Administration Records	
b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN	contained missing entries. No documentation found indicating reason for missing entries: • Fluticasone Prop 50 MCG Spray (1 time	
prescriptions or treatments; over the	daily) – Blank 12/2, 4 - 31 (8:00 AM)	

- counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy.
- Documentation of all time limited or discontinued medications or treatments.
- d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials.
- e. Documentation of refused, missed, or held medications or treatments.
- f. Documentation of any allergic reaction that occurred due to medication or treatments; and
- g. For PRN medications or treatments:
 - i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period.
 - ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and
 - iii. documentation of the effectiveness of the PRN medication or treatment.

Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery:

Living Supports Provider Agencies must support and comply with:

1. the processes identified in the DDSD AWMD training.

 Olanzapine 20mg (1 time daily) – Blank 12/1 (8:00 PM)

January 2022

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

- Fluticasone Prop 50 MCG Spray (1 time daily) – Blank 1/1 - 4 (8:00 AM)
- Errin 0.35 (1 time daily) Blank 1/3 (8:00 AM)

Medication Administration Records did not contain medication found in the home:

• Olanzapine 10mg (2 times daily)

Individual #5

January 2022

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

 Topiramate F/C 100mg (3 times daily) – Blank 1/2 (4:00 PM)

Individual #6

December 2021

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

 Mupirocin 2% Ointment (1 time daily) – Blank 12/1 - 31 (7:00 AM & 5:00 PM)

As indicated by the Medication
Administration Records the individual is to take Debrox 6.5% (3 times week).
According to the Physician's Orders, Debrox 6.5% is to be taken 2 times daily. Medication Administration Record and Physician's Orders do not match.

- 2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services;
- 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and
- 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).

NMAC 16.19.11.8 MINIMUM STANDARDS:

A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:

(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications.

This documentation shall include:

i ilis documentation shall incit

- (i) Name of resident.
- (ii) Date given.
- (iii) Drug product name.
- (iv) Dosage and form.
- (v) Strength of drug.
- (vi) Route of administration.
- (vii) How often medication is to be taken.
- (viii) Time taken and staff initials.
- (ix) Dates when the medication is discontinued or changed.
- (x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual D. Administration of Drugs

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications.

Document the practitioner's order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the

Individual #7

December 2021

Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records:

Benzoyl Peroxide 10% Gel (1 time daily)

Individual #9

December 2021

Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:

- Minerin Crème (1 time daily)
- Urea 20% Topical Cream (1 time daily)

January 2022

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

- Fish Oil 1000mg (2 times daily) Blank 1/1
 4 (8:00 AM), 1/1 3 (8:00 PM)
- Gabapentin 300mg (2 times daily) Blank 1/1 – 4 (8:00 AM), 1/1 – 3 (8:00 PM)
- Minerin Crème (1 time daily) Blank 1/1 3 (8:00 PM)
- Multi Vitamin (1 time daily) Blank 1/1 3 (8:00 PM)
- Pravastatin Sodium 80mg (1 time daily) Blank 1/1 – 3 (8:00 PM)
- Risperidone 3mg (2 times daily) Blank
 1/1 4 (8:00 AM), 1/1 3 (8:00 PM)
- Sertraline 100mg (1 time daily) Blank 1/1
 3 (8:00 PM)

administering of the medication. This shall include: > symptoms that indicate the use of the medication, > exact dosage to be used, and > the exact amount to be used in a 24-hour period.	 Vitamin D3 5000 unit (1 time daily) – Blank 1/1 – 3 (8:00 PM) Medication Administration Records did not contain medication found in the home: Fluvoxamine ER 100mg (1 time daily) Levothyroxine 25mcg (1 time daily) Losartan Potassium 100mg (1 time daily) As indicated by Medication Administration Record the individual is to take the following medication. No evidence of the medication in the home. Risperidone 3mg (2 times daily) 	

Tag # 1A09.0 Medication Delivery Routine Medication Administration	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver	Medication Administration Records (MAR)	Provider:	
Service Standards 2/26/2018; Re-Issue:	were reviewed for the months of December	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	2021 and January 2022	deficiencies cited in this tag here (How is the	
Chapter 20: Provider Documentation and	, , , , , , , , , , , , , , , , , , , ,	deficiency going to be corrected? This can be	
Client Records 20.6 Medication	Based on record review, 5 of 9 individuals had	specific to each deficiency cited or if possible an	
Administration Record (MAR): A current	Medication Administration Records (MAR),	overall correction?): \rightarrow	
Medication Administration Record (MAR) must	which contained missing medications entries		
be maintained in all settings where	and/or other errors:		
medications or treatments are delivered.			
Family Living Providers may opt not to use	Individual #5		
MARs if they are the sole provider who	December 2021		
supports the person with medications or	Medication Administration Records did not		
treatments. However, if there are services	contain the diagnosis for which the		
provided by unrelated DSP, ANS for	medication is prescribed:	Provider:	
Medication Oversight must be budgeted, and a	 Fluoxetine HCL 20mg (1 time daily) 	Enter your ongoing Quality	
MAR must be created and used by the DSP.	i idenomia i ide zamg (i imila dam),	Assurance/Quality Improvement	
Primary and Secondary Provider Agencies are	Propranolol ER 120mg (1 time daily)	processes as it related to this tag number	
responsible for:	1 repranded Ert (Zering (1 time daily)	here (What is going to be done? How many	
Creating and maintaining either an	Individual #6	individuals is this going to affect? How often will	
electronic or paper MAR in their service	December 2021	this be completed? Who is responsible? What	
setting. Provider Agencies may use the	Medication Administration Records did not	steps will be taken if issues are found?): →	
MAR in Therap but are not mandated to	contain the diagnosis for which the		
do so.	medication is prescribed:		
2. Continually communicating any	Benztropine (1 time daily)		
changes about medications and	Donza opino (1 amo dany)		
treatments between Provider Agencies to	Debrox 6.5% (3 times week)		
assure health and safety.	Bobiek 0.070 (6 times wook)		
8. Including the following on the MAR:	Medication Administration Records did not		
a. The name of the person, a	contain the dosage for the following		
transcription of the physician's or	medications:		
licensed health care provider's orders	Benztropine (1 time daily)		
including the brand and generic	benziropine (1 time daily)		
names for all ordered routine and PRN	Medication Administration Records did not		
medications or treatments, and the	contain the strength of the medication which		
diagnoses for which the medications	is to be given:		
or treatments are prescribed.	Benztropine (1 time daily)		
b. The prescribed dosage, frequency	- Bonzaopino (1 anto dany)		
and method or route of administration;	Medication Administration Record did not		
times and dates of administration for	contain the specific time(s) the medication		
all ordered routine or PRN	Something opening arrio(o) the medication		
prescriptions or treatments; over the			

- counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy.
- Documentation of all time limited or discontinued medications or treatments.
- d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials.
- e. Documentation of refused, missed, or held medications or treatments.
- f. Documentation of any allergic reaction that occurred due to medication or treatments; and
- g. For PRN medications or treatments:
 - i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period.
 - ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and
 - iii. documentation of the effectiveness of the PRN medication or treatment.

Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery:

Living Supports Provider Agencies must support and comply with:

1. the processes identified in the DDSD AWMD training.

- should be given, for the following medications:
- Austedo 6mg (2 times daily)

Individual #7

December 2021

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Benztropine 1mg (1 time daily)
- Quetiapine 25mg (1 time daily)
- Vitamin D3 1,000 Unit (1 time daily)

Individual #9

December 2021

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Fluvoxamine Maleate 100mg (1 time daily)
- Multivitamin with Iron (1 time daily)
- Quetiapine Fumarate 100mg (2 times daily)
- Risperdal 2mg (2 times daily)

As indicated by the Medication Administration Records the route for Minerin Crème was Oral. According to the <u>label</u> <u>directions</u>, the route is to be applied to skin. Medication Administration Record and <u>label</u> directions do not match.

Individual #11

December 2021

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

Zolpidem Tartrate 5mg (1 time daily)

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).		
NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include: (i) Name of resident. (ii) Date given. (iii) Drug product name. (iv) Dosage and form. (v) Strength of drug. (vi) Route of administration. (vii) How often medication is to be taken. (viii) Time taken and staff initials. (ix) Dates when the medication is discontinued or changed. (x) The name and initials of all staff administering medications.		
Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have		

administering of the medication. This shall		
include:		
> symptoms that indicate the use of the		
symptoms that indicate the use of the		
medication,		
exact dosage to be used, and		
the exact amount to be used in a 24-		
hour period.		
flour period.		

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver	After an analysis of the evidence, it has been	Provider:	
Service Standards 2/26/2018; Re-Issue:	determined there is a significant potential for a	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	negative outcome to occur.	deficiencies cited in this tag here (How is the	
Chapter 20: Provider Documentation and	l legative outcome to occur.	deficiency going to be corrected? This can be	
Client Records 20.6 Medication	Medication Administration Records (MAR)	specific to each deficiency cited or if possible an	
Administration Record (MAR): A current	were reviewed for the months of December	overall correction?): \rightarrow	
Medication Administration Record (MAR) must	2021 and January 2022.		
be maintained in all settings where	2021 and dandary 2022.		
medications or treatments are delivered.	Based on record review, 9 of 9 individuals had		
Family Living Providers may opt not to use	PRN Medication Administration Records		
MARs if they are the sole provider who	(MAR), which contained missing elements as		
supports the person with medications or	required by standard:		
treatments. However, if there are services	required by standard.		
provided by unrelated DSP, ANS for	Individual #1	Provider:	
Medication Oversight must be budgeted, and a	December 2021	Enter your ongoing Quality	
MAR must be created and used by the DSP.	No evidence of documented	Assurance/Quality Improvement	
Primary and Secondary Provider Agencies are	Signs/Symptoms were found for the	processes as it related to this tag number	
responsible for:	following PRN medication:	here (What is going to be done? How many	
Creating and maintaining either an	Haloperidol 5mg— PRN – 12/14 (given 1)	individuals is this going to affect? How often will	
electronic or paper MAR in their service	time)	this be completed? Who is responsible? What	
setting. Provider Agencies may use the	uno,	steps will be taken if issues are found?): →	
MAR in Therap but are not mandated to	No Effectiveness was noted on the		
do so.	Medication Administration Record for the		
Continually communicating any	following PRN medication:		
changes about medications and	Haloperidol 5mg – PRN – 12/14 (given 1)		
treatments between Provider Agencies to	time)		
assure health and safety.			
7. Including the following on the MAR:	No Time of Administration was noted on the		
a. The name of the person, a	Medication Administration Record for the		
transcription of the physician's or	following PRN medication:		
licensed health care provider's orders	Haloperidol 5mg – PRN – 12/14 (given 1)		
including the brand and generic	time)		
names for all ordered routine and PRN			
medications or treatments, and the	Individual #2		
diagnoses for which the medications	December 2021		
or treatments are prescribed.	No Effectiveness was noted on the		
b. The prescribed dosage, frequency	Medication Administration Record for the		
and method or route of administration;	following PRN medication:		
times and dates of administration for	Melatonin 3mg – PRN – 12/15 (given 1)		
all ordered routine or PRN	time)		
prescriptions or treatments; over the	,		

- counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy.
- c. Documentation of all time limited or discontinued medications or treatments.
- d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials.
- e. Documentation of refused, missed, or held medications or treatments.
- f. Documentation of any allergic reaction that occurred due to medication or treatments; and
- g. For PRN medications or treatments:
 - i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period.
 - ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and
 - iii. documentation of the effectiveness of the PRN medication or treatment.

Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery:

Living Supports Provider Agencies must support and comply with:

1. the processes identified in the DDSD AWMD training.

As indicated by the Medication Administration Records the individual is to take Chloraseptic Spray (PRN) 1 spray every 4 hours. According to the Physician's Orders, Chloraseptic Spray (PRN) is to be taken 1 time every hour as needed. Medication Administration Record and Physician's Orders do not match.

As indicated by the Medication Administration Records the individual is to take Mylanta (PRN) 1 or 2 teaspoons every 2 - 4 hours. According to the Physician's Orders, Mylanta (PRN) is to be taken every 4 - 6 hours. Medication Administration Record and Physician's Orders do not match.

Individual #5 December 2021

> No evidence of documented Signs/Symptoms were found for the following PRN medication:

- Loperamide − PRN − 12/16, x (given 1 time)
- Risperidone .05mg PRN 12/6 (given 1 time)

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:

- Loperamide PRN 12/16, x (given 1 time)
- Risperidone .5mg PRN 12/6 (given 1 time)

No Time of Administration was noted on the Medication Administration Record for the following PRN medication:

- 2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services;
- 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and
- documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).

- Loperamide PRN 12/16 (given 1 time)
- Risperidone .5mg PRN 12/6 (given 1 time)

Individual #6 December 2021

As indicated by the Medication Administration Records the individual is to take Lorazepam 0.5mg (PRN) 1 - 2 tablet(s) one time daily as needed. According to the Physician's Orders, Lorazepam 0.5mg, 1 tablet by mouth daily prior to medical appointments and 1 - 2 tablets daily for anxiety/agitation as needed Medication Administration Record and Physician's Orders do not match.

Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:

• Fluocinonide 0.05% Cream (PRN)

Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records:

• Acetaminophen 325mg (PRN)

Individual #7
December 2021

Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:

- Benadryl 2% Gel (PRN)
- Hydrocortisone 1% Cream (PRN)

Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: Acetaminophen 500mg (PRN) • Benzoyl Peroxide 10% Gel (PRN) Individual #8 December 2021 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Diaper Rash Paste - PRN -12/5 (given 2 times) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Diaper Rash Cream (PRN) Individual #9 December 2021 During on-site survey PRN Medication Administration Records were requested for month of 12/2021. As of 1/14/2022, Medication Administration Records for December 2021 had not been provided. January 2022 Medication Administration Records did not contain medication found in the home: • Hydroxyzine 25mg – PRN (3x daily) Individual #10 December 2021 No Effectiveness was noted on the Medication Administration Record for the

following PRN medication:

12/3, 17, 23 (given 1 time)

Acetaminophen 325 or 500mg – PRN –

- Cough Drops PRN 12/1 2 (given 1 time)
- Guiatuss PRN 12/1, 4 (given 1 time), 12/2 (given 2 times), 12/3 (given 3 times)

No Time of Administration was noted on the Medication Administration Record for the following PRN medication:

Guiatuss – PRN – 12/1, 4 (given 1 time),
 12/2 (given 2 times)

As indicated by the Medication Administration Records the individual is to take Hydroxyzine 10mg (PRN), 1 tablet daily as needed. According to the Physician's Orders, Hydroxyzine 10mg is to be taken 1 time daily for 90 days. Medication Administration Record and Physician's Orders do not match.

Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records:

- Eucerin Cream (PRN)
- Ibuprofen 200mg (PRN)

Individual #11
December 2021

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:

 Acetaminophen 500mg – PRN – 12/8 (given 1 time)

As indicated by the Medication Administration Records the individual is to take Cough Drops (PRN), 1 drop. According to the Physician's Orders, Cough Drops is to

Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver	Medication Administration Records (MAR)	Provider:	
Service Standards 2/26/2018; Re-Issue:	were reviewed for the months of December	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	2021 and January 2022.	deficiencies cited in this tag here (How is the	
Chapter 20: Provider Documentation and	2021 and bandary 2022.	deficiency going to be corrected? This can be	
Client Records 20.6 Medication	Based on record review, 3 of 9 individuals had	specific to each deficiency cited or if possible an	
Administration Record (MAR): A current	PRN Medication Administration Records	overall correction?): →	
Medication Administration Record (MAR) must	(MAR), which contained missing elements as		
be maintained in all settings where	required by standard:		
medications or treatments are delivered.	Toquirou by olaridara.		
Family Living Providers may opt not to use	Individual #2		
MARs if they are the sole provider who	December 2021		
supports the person with medications or	Medication Administration Records did not		
treatments. However, if there are services	contain the exact amount to be used in a		
provided by unrelated DSP, ANS for	24-hour period:	Provider:	
Medication Oversight must be budgeted, and a	Acetaminophen 500mg (PRN)	Enter your ongoing Quality	
MAR must be created and used by the DSP.	Troctariniophori doding (France)	Assurance/Quality Improvement	
Primary and Secondary Provider Agencies are		processes as it related to this tag number	
responsible for:	Codgii Diops (i 1(14)	here (What is going to be done? How many	
Creating and maintaining either an	Deep Sea Spray (PRN) ■	individuals is this going to affect? How often will	
electronic or paper MAR in their service	Deep Sea Spray (FRR)	this be completed? Who is responsible? What	
setting. Provider Agencies may use the	■Ibuprofen 200mg (PRN)	steps will be taken if issues are found?): \rightarrow	
MAR in Therap but are not mandated to	bupfolen zoonig (FKN)		
do so.	- Dink Pinmol (DDNI)		
Continually communicating any	Pink Bismol (PRN)		
changes about medications and	Individual #5		
treatments between Provider Agencies to	December 2021		
assure health and safety.	Medication Administration Records did not		
7. Including the following on the MAR:	contain the exact amount to be used in a		
a. The name of the person, a	24-hour period:		
transcription of the physician's or	Chloraseptic Spray (PRN)		
licensed health care provider's orders	Cilioraseptic Spray (FIXIV)		
including the brand and generic	Cough Drops (PRN)		
names for all ordered routine and PRN	Cough blops (FKN)		
medications or treatments, and the	Individual #6		
diagnoses for which the medications	December 2021		
or treatments are prescribed.	Medication Administration Records did not		
b. The prescribed dosage, frequency	contain the exact amount to be used in a		
and method or route of administration;	24-hour period:		
times and dates of administration for	Acetaminophen 500mg (PRN)		
all ordered routine or PRN	Acetaminophen boomy (PKN)		
prescriptions or treatments; over the			

counter (OTC) or "comfort"	Chloraseptic Spray (PRN)	
medications or treatments and all self- selected herbal or vitamin therapy.		
c. Documentation of all time limited or discontinued medications or treatments.	Ibuprofen 200mg (PRN) ■	
d. The initials of the individual administering or assisting with the	Ocean Mist Spray (PRN)	
medication delivery and a signature page or electronic record that		
designates the full name	Medication Administration Records did not contain the circumstance for which the	
corresponding to the initials. e. Documentation of refused, missed, or	medication is to be used: • Chloraseptic Spray (PRN)	
held medications or treatments. f. Documentation of any allergic	, , ,	
reaction that occurred due to medication or treatments; and		
g. For PRN medications or treatments:		
 i. instructions for the use of the PRN medication or treatment which must 		
include observable signs/symptoms or circumstances in which the		
medication or treatment is to be used and the number of doses that may be		
used in a 24-hour period.		
ii. clear documentation that the DSP contacted the agency nurse		
prior to assisting with the medication or treatment, unless		
the DSP is a Family Living Provider related by affinity of		
consanguinity; and		
iii. documentation of the effectiveness of the PRN		
medication or treatment.		
Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and		

Delivery:

AWMD training.

Living Supports Provider Agencies must support and comply with:

1. the processes identified in the DDSD

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).		

Tag # 1A09.2 Medication Delivery Nurse	Condition of Participation Level Deficiency		
Approval for PRN Medication			
Developmental Disabilities (DD) Waiver	After an analysis of the evidence, it has been	Provider:	
Service Standards 2/26/2018; Re-Issue:	determined there is a significant potential for a	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	negative outcome to occur.	deficiencies cited in this tag here (How is the	
Chapter 13 Nursing Services: 13.2.12		deficiency going to be corrected? This can be	
Medication Delivery: Nurses are required to:	Based on record review the Agency did not	specific to each deficiency cited or if possible an	
Be aware of the New Mexico Nurse	maintain documentation of PRN authorization	overall correction?): \rightarrow	
Practice Act, and Board of Pharmacy	as required by standard for 4 of 9 Individuals.		
standards and regulations.			
Communicate with the Primary Care	Individual #1		
Practitioner and relevant specialists regarding	December 2021		
medications and any concerns with	No documentation of the verbal		
medications or side effects.	authorization from the Agency nurse prior to		
3. Educate the person, guardian, family, and	each administration/assistance of PRN	B	
IDT regarding the use and implications of	medication was found for the following PRN	Provider:	
medications as needed.	medication:	Enter your ongoing Quality	
4. Administer medications when required,	 Haloperidol 5mg – PRN – 12/14 (given 1 	Assurance/Quality Improvement	
such as intravenous medications; other	time)	processes as it related to this tag number	
specific injections; via NG tube; non-premixed		here (What is going to be done? How many	
nebulizer treatments or new prescriptions that	Individual #2	individuals is this going to affect? How often will this be completed? Who is responsible? What	
have an ordered assessment.	December 2021	steps will be taken if issues are found?): →	
5. Monitor the MAR or treatment records at	No documentation of the verbal	stops will be taken in issues are round:).	
least monthly for accuracy, PRN use and	authorization from the Agency nurse prior to		
errors.	each administration/assistance of PRN		
6. Respond to calls requesting delivery of	medication was found for the following PRN		
PRNs from AWMD trained DSP and non-	medication:		
related (surrogate or host) Family Living	 Olanzapine 5mg – PRN – 12/19 (given 1 		
Provider Agencies.	time)		
7. Assure that orders for PRN medications or			
treatments have:	Individual #5		
a. clear instructions for use.	December 2021		
b. observable signs/symptoms or	No documentation of the verbal		
circumstances in which the medication	authorization from the Agency nurse prior to		
is to be used or withheld; and	each administration/assistance of PRN		
c. documentation of the response to and	medication was found for the following PRN		
effectiveness of the PRN medication	medication:		
administered.	Loperamide 10mg − PRN − 12/16 (given 1		
8. Monitor the person's response to the use of	time)		
routine or PRN pain medication and contact the			
prescriber as needed regarding its	• Risperidone .5mg – PRN – 12/9, 21 (given		
effectiveness.	1 time)		
Assure clear documentation when PRN			

medications are used, to include: a. DSP contact with nurse prior to assisting with medication. i. The only exception to prior consultation with the agency nurse is to administer selected emergency medications as listed on the Publications section of the DOH-DDSD -Clinical Services Website https://nmhealth.org/about/ddsd/pgsv/clinical/ b. Nursing instructions for use of the medication. c. Nursing follow-up on the results of the PRN use. d. When the nurse administers the PRN medication, the reasons why the medications were given and the person's response to the medication.	Individual #11 January 2022 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Lorazepam 1mg – PRN – 1/4 (given 1 time)	

Tag # 1A15.2 Administrative Case File:	Condition of Participation Level Deficiency		
Healthcare Documentation (Therap and	Condition of Farticipation Level Deliciency		
Required Plans)			
Developmental Disabilities (DD) Waiver	After an analysis of the evidence, it has been	Provider:	
Service Standards 2/26/2018; Re-Issue:	determined there is a significant potential for a	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	negative outcome to occur.	deficiencies cited in this tag here (How is the	
Chapter 20: Provider Documentation and		deficiency going to be corrected? This can be	
Client Records: 20.2 Client Records	Based on record review, the Agency did not	specific to each deficiency cited or if possible an	
Requirements: All DD Waiver Provider	maintain the required documentation in the	overall correction?): →	
Agencies are required to create and maintain	Individuals Agency Record as required by		
individual client records. The contents of client	standard for 4 of 9 individual		
records vary depending on the unique needs			
of the person receiving services and the	Review of the administrative individual case		
resultant information produced. The extent of	files revealed the following items were not		
documentation required for individual client	found, incomplete, and/or not current:		
records per service type depends on the		Para titan	
location of the file, the type of service being	Healthcare Passport:	Provider:	
provided, and the information necessary.	Did not contain Guardianship / Healthcare	Enter your ongoing Quality	
DD Waiver Provider Agencies are required to	Decision Maker (#1, 2, 9) (Note: Individual	Assurance/Quality Improvement	
adhere to the following:	#9 completed in Therap during the on-site	processes as it related to this tag number here (What is going to be done? How many	
Client records must contain all documents	survey. Provider please complete POC for	individuals is this going to affect? How often will	
essential to the service being provided and	ongoing QA/QI.)	this be completed? Who is responsible? What	
essential to ensuring the health and safety of		steps will be taken if issues are found?): \rightarrow	
the person during the provision of the service.	Did not contain Name of Physician (#1, 9)		
Provider Agencies must have readily	(Note: Completed in Therap during the on-		
accessible records in home and community	site survey. Provider please complete POC		
settings in paper or electronic form. Secure	for ongoing QA/QI.)		
access to electronic records through the	Did not contain Information Departing		
Therap web-based system using computers or	➤ Did not contain Information Regarding Insurance (#5) (Note: Completed in Therap		
mobile devices is acceptable.	during the on-site survey. Provider please		
3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs,	complete POC for ongoing QA/QI.)		
therapists or BSCs are present in all needed	Complete FOC for origining QA/QI.)		
settings.			
4. Provider Agencies must maintain records			
of all documents produced by agency			
personnel or contractors on behalf of each			
person, including any routine notes or data,			
annual assessments, semi-annual reports,			
evidence of training provided/received,			
progress notes, and any other interactions for			
which billing is generated.			
5. Each Provider Agency is responsible for			

maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.		
Chapter 3 Safeguards: 3.1.1 Decision Consultation Process (DCP): Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: 2. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or		

Dentist.

b.	clinical recommendations made by	
	registered/licensed clinicians who are	!
	either members of the IDT or clinicians	!
	who have performed an evaluation such	
	as a video-fluoroscopy.	
C.	health related recommendations or	
	suggestions from oversight activities such	
	as the Individual Quality Review (IQR) or	
	other DOH review or oversight activities;	
اہ	and	
a.	recommendations made through a	
	Healthcare Plan (HCP), including a Comprehensive Aspiration Risk	
	Management Plan (CARMP), or another	
	plan.	!
	pan.	!
2. W	/hen the person/guardian disagrees with a	
	ommendation or does not agree with the	
	ementation of that recommendation,	
Prov	vider Agencies follow the DCP and attend	!
the	meeting coordinated by the CM. During	
	meeting:	
а	. 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	!
h	of the recommendation. The information will be focused on the	
D	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.	
С	Providers support the person/guardian to	!
	make an informed decision.	
d	. The decision made by the	!
	person/guardian during the meeting is	
	accepted; plans are modified; and the	
	IDT honors this health decision in every	

setting.

Chapter 13 Nursing Services: 13.2.5 Electronic Nursing Assessment and **Planning Process:** The nursing assessment process includes several DDSD mandated tools: the electronic Comprehensive Nursing Assessment Tool (e-CHAT), the Aspiration Risk Screening Tool (ARST) and the Medication Administration Assessment Tool (MAAT) . This process includes developing and training Health Care Plans and Medical Emergency Response Plans. 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. The hierarchy for Nursing Assessment and Planning responsibilities is: 1. Living Supports: Supported Living, IMLS or Family Living via ANS. 2. Customized Community Supports- Group; and 3. Adult Nursing Services (ANS): a. for persons in Community Inclusion with health-related needs; or b. if no residential services are budgeted but assessment is desired and health needs may exist. 13.2.6 The Electronic Comprehensive Health Assessment Tool (e-CHAT) 1. The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person. 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.

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.		
4. When completing the e-CHAT, the nurse is		
required to review and update the electronic		
record and consider the diagnoses,		
medications, treatments, and overall status of		
the person. Discussion with others may be		
needed to obtain critical information.		
5. The nurse is required to complete all the e-		
CHAT assessment questions and add		
additional pertinent information in all comment		
sections.		
13.2.7 Aspiration Risk Management		
Screening Tool (ARST)		
42.2.0 Madication Administration		
13.2.8 Medication Administration		
Assessment Tool (MAAT): 1. A licensed nurse completes the		
DDSD Medication Administration		
Assessment Tool (MAAT) at least two		
weeks before the annual ISP meeting.		
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.		
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.		

13.2.9 Healthcare Plans (HCP):

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 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 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.			
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.			
LUTOGOTHIU SILUGUOTI.	1	1	

Chapter 20: Provider Documentation and		
Client Records: 20.5.3 Health Passport and		
Physician Consultation Form: 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.		

Tag # 1A27.2 Duty to Report IRs Filed	Standard Level Deficiency		
During On-Site and/or IRs Not Reported by	Standard Level Deliciency		
Provider			
NMAC 7.1.14.8 INCIDENT MANAGEMENT	Based on observation, the Agency did not	Provider:	
SYSTEM REPORTING REQUIREMENTS FOR	report suspected abuse, neglect, or	State your Plan of Correction for the	
COMMUNITY-BASED SERVICE PROVIDERS:	exploitation, unexpected and natural/expected	deficiencies cited in this tag here (How is the	
A. Duty to report:	deaths; or other reportable incidents as	deficiency going to be corrected? This can be	
(1) All community-based providers shall	required to the Division of Health Improvement.	specific to each deficiency cited or if possible an	
immediately report alleged crimes to law		overall correction?): →	
enforcement or call for emergency medical	The following internal incidents were reported		
services as appropriate to ensure the safety of	as a result of the on-site survey:		
consumers.			
(2) All community-based service providers,	During the on-site survey on January 3 -		
their employees and volunteers shall	14, 2022, surveyors observed the following:		
immediately call the department of health			
improvement (DHI) hotline at 1-800-445-6242 to	 During the on-site visit on 1/4/2022 at 4:00 	Provider:	
report abuse, neglect, exploitation, suspicious	PM to the residence of Individual #1,	Enter your ongoing Quality	
injuries or any death and also to report an	Surveyor's observed a Direct Support	Assurance/Quality Improvement	
environmentally hazardous condition which	Personnel not wearing a mask in the home	processes as it related to this tag number	
creates an immediate threat to health or safety.	while providing direct care services for the	here (What is going to be done? How many	
B. B. and an array framework All and array of	individual. As a result of what was	individuals is this going to affect? How often will	
B. Reporter requirement. All community-	observed a State ANE Report was reported	this be completed? Who is responsible? What	
based service providers shall ensure that the	to DHI.	steps will be taken if issues are found?): →	
employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious	D 2 1 1 1 1 2 2 2 1 2 2 2 2 2 2 2 2 2 2		
injury, or death calls the division's hotline to	During the on-site visit on 1/4/2022 at 5:45 DM to the residence of Individual #2		
report the incident.	PM to the residence of Individual #2,		
report the incident.	Surveyor's observed a Direct Support Personnel not wearing a mask in the home		
C. Initial reports, form of report, immediate	while providing direct care services for the		
action and safety planning, evidence	individual. As a result of what was		
preservation, required initial notifications:	observed a State ANE Report was reported		
(1) Abuse, neglect, and exploitation,	to DHI.		
suspicious injury or death reporting: Any	10 D111.		
person may report an allegation of abuse,	During the on-site visit on 1/4/2022 at 3:45		
neglect, or exploitation, suspicious injury or a	PM to the residence of Individual #9,		
death by calling the division's toll-free hotline	Surveyor's observed a Direct Support		
number 1-800-445-6242. Any consumer, family	Personnel not wearing a mask in the home		
member, or legal guardian may call the division's	while providing direct care services for the		
hotline to report an allegation of abuse, neglect,	individual. As a result of what was		
or exploitation, suspicious injury or death	observed a State ANE Report was reported		
directly, or may report through the community-	to DHI.		
based service provider who, in addition to calling			
the hotline, must also utilize the division's abuse,			

neglect, and exploitation or report of death form.		
The abuse, neglect, and exploitation or report of		
death form and instructions for its completion		
and filing are available at the division's website,		
http://dhi.health.state.nm.us, or may be obtained		
from the department by calling the division's toll-		
free hotline number, 1-800-445-6242.		
(2) Use of abuse, neglect, and exploitation		
or report of death form and notification by		
community-based service providers: In		
addition to calling the division's hotline as		
required in Paragraph (2) of Subsection A of		
7.1.14.8 NMAC, the community-based service		
provider shall also report the incident of abuse,		
neglect, exploitation, suspicious injury, or death		
utilizing the division's abuse, neglect, and		
exploitation or report of death form consistent		
with the requirements of the division's abuse,		
neglect, and exploitation reporting guide. The		
community-based service provider shall ensure		
all abuse, neglect, exploitation or death reports		
describing the alleged incident are completed on		
the division's abuse, neglect, and exploitation or		
report of death form and received by the division		
within 24 hours of the verbal report. If the		
provider has internet access, the report form		
shall be submitted via the division's website at		
http://dhi.health.state.nm.us; otherwise, it may		
be submitted via fax to 1-800-584-6057. The		
community-based service provider shall ensure		
that the reporter with the most direct knowledge		
of the incident participates in the preparation of		
the report form.		
(3) Limited provider investigation: No		
investigation beyond that necessary in order to		
be able to report the abuse, neglect, or		
exploitation and ensure the safety of consumers		
is permitted until the division has completed its		
investigation.		
(4) Immediate action and safety planning:		
Upon discovery of any alleged incident of abuse,		
neglect, or exploitation, the community-based		
service provider shall:		

(a) develop and implement an		
immediate action and safety plan for any		
potentially endangered consumers, if		
applicable.		
(b) be immediately prepared to report		
that immediate action and safety plan		
verbally, and revise the plan according to		
the division's direction, if necessary; and		
(c) provide the accepted immediate		
action and safety plan in writing on the		
immediate action and safety plan form		
within 24 hours of the verbal report. If the		
provider has internet access, the report		
form shall be submitted via the division's		
website at http://dhi.health.state.nm.us;		
otherwise, it may be submitted by faxing it		
to the division at 1-800-584-6057.		
(5) Evidence preservation: The community-		
based service provider shall preserve evidence		
related to an alleged incident of abuse, neglect,		
or exploitation, including records, and do nothing		
to disturb the evidence. If physical evidence		
must be removed or affected, the provider shall		
take photographs or do whatever is reasonable		
to document the location and type of evidence		
found which appears related to the incident.		
(6) Legal guardian or parental notification:		
The responsible community-based service		
provider shall ensure that the consumer's legal		
guardian or parent is notified of the alleged		
incident of abuse, neglect and exploitation within		
24 hours of notice of the alleged incident unless		
the parent or legal guardian is suspected of		
committing the alleged abuse, neglect, or		
exploitation, in which case the community-based		
service provider shall leave notification to the		
division's investigative representative.		
(7) Case manager or consultant		
notification by community-based service	ļ	
providers: The responsible community-based	ļ	
service provider shall notify the consumer's case	ļ	
manager or consultant within 24 hours that an		

alleged incident involving abuse, neglect, or

exploitation has been reported to the division.		
Names of other consumers and employees may		
be redacted before any documentation is		
forwarded to a case manager or consultant.		
(8) Non-responsible reporter: Providers		
who are reporting an incident in which they are		
not the responsible community-based service		
provider shall notify the responsible community-		
based service provider within 24 hours of an		
incident or allegation of an incident of abuse,		
neglect, and exploitation.		
riegicot, and exploitation.		

Tag # 1A31 Client Rights / Human Rights	Condition of Participation Level Deficiency		
NMAC 7.26.3.11 RESTRICTIONS OR	After an analysis of the evidence, it has been	Provider:	
LIMITATION OF CLIENT'S RIGHTS:	determined there is a significant potential for a	State your Plan of Correction for the	
A. A service provider shall not restrict or limit	negative outcome to occur.	deficiencies cited in this tag here (How is the	
a client's rights except:		deficiency going to be corrected? This can be	
(1) where the restriction or limitation is	Based on record review, the Agency did not	specific to each deficiency cited or if possible an	
allowed in an emergency and is necessary to	ensure the rights of Individuals was not	overall correction?): →	
prevent imminent risk of physical harm to the	restricted or limited for 1 of 9 Individuals.		
client or another person; or			
(2) where the interdisciplinary team has	No documentation was found regarding		
determined that the client's limited capacity	Human Rights Approval for the following:		
to exercise the right threatens his or her			
physical safety; or	Limited Facetime with Family Members - No		
(3) as provided for in Section 10.1.14 [now	evidence found of Human Rights Committee	Brevider	
Subsection N of 7.26.3.10 NMAC].	approval. (Individual #7)	Provider:	
		Enter your ongoing Quality Assurance/Quality Improvement	
B. Any emergency intervention to prevent	Locked cabinets and pantry - No evidence	processes as it related to this tag number	
physical harm shall be reasonable to prevent	found of Human Rights Committee	here (What is going to be done? How many	
harm, shall be the least restrictive	approval. (Individual #7)	individuals is this going to affect? How often will	
intervention necessary to meet the		this be completed? Who is responsible? What	
emergency, shall be allowed no longer than	Restricted Internet - No evidence found of	steps will be taken if issues are found?): →	
necessary and shall be subject to	Human Rights Committee approval.		
interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its	(Individual #7)		
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.			
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]			
B 1 (18) (19) (25)			
Developmental Disabilities (DD) Waiver			
Service Standards 2/26/2018; Re-Issue:			
12/28/2018; Eff 1/1/2019			
Chapter 2: Human Rights: Civil rights apply			
to everyone, including all waiver participants,			
family members, guardians, natural supports,			1

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 obligation to contribute to the planning process, always focusing on how to best support the person.		
Chapter 3 Safeguards: 3.3.1 HRC Procedural Requirements: 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. 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. 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. 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. 5. HRC committees are required to meet at least on a quarterly basis. 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.

7. HRC members who are directly involved in the services provided to the person must excuse themselves from voting in that situation. Each HRC is required to have a provision for emergency approval of rights restrictions based 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. 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.		
3.3.3 HRC and Behavioral Support: 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		

	hy relationships) to increase the person's		
	ty of life understanding that a natural		
	ction in other challenging behaviors will	1	
	v. At times, aversive interventions may be	1	
	orarily included as a part of a person's	1	
	vioral support (usually in the BCIP), and	1	
	fore, need to be reviewed prior to		
	ementation as well as periodically while		
	estrictive intervention is in place. PBSPs		
	ontaining aversive interventions do not		
	re HRC review or approval.	1	
	s (e.g., ISPs, PBSPs, BCIPs PPMPs,		
	or RMPs) that contain any aversive		
	ventions are submitted to the HRC in	1	
	nce of a meeting, except in emergency		
situa	tions.	1	
	Interventions Requiring HRC Review		
	Approval: HRCs must review prior to		
	ementation, any plans (e.g., ISPs, PBSPs,		
	Ps and/or PPMPs, RMPs), with strategies,		
	ding but not limited to:	1	
1.	response cost.		
2.	restitution.		
3.	emergency physical restraint (EPR).		
4.	routine use of law enforcement as part of		
_	a BCIP.		
5.	routine use of emergency hospitalization	1	
c	procedures as part of a BCIP.		
6. 7.	use of point systems.		
7.	use of intense, highly structured, and	1	
	specialized treatment strategies,		
	including level systems with response		
8.	cost or failure to earn components.		
ο.	a 1:1 staff to person ratio for behavioral		
	reasons, or, very rarely, a 2:1 staff to		
	person ratio for behavioral or medical		
0	reasons.		
9. 10	use of PRN psychotropic medications.		
10.	use of protective devices for behavioral		
	purposes (e.g., helmets for head		
	banging, Posey gloves for biting hand).		

11. use of bed rails.

 12. use of a device and/or monitoring system through PST may impact the person's privacy or other rights; or 13. use of any alarms to alert staff to a person's whereabouts. 		
3.4 Emergency Physical Restraint (EPR): 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 intervention such as Emergency Physical Restraint (EPR) are required to institute procedures to maximize safety.		
 3.4.5 Human Rights Committee: 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: 1. participate in training regarding required constitution and oversight activities for HRCs. 2. review any BCIP, that include the use of EPR. 3. occur at least annually, occur in any quarter where EPR is used, and occur whenever any change to the BCIP is considered. 4. maintain HRC minutes approving or disallowing the use of EPR as written in a BCIP; and 5. maintain HRC minutes of meetings reviewing the implementation of the BCIP when EPR is used. 		

Tag # LS25 Residential Health & Safety	Standard Level Deficiency		
(Supported Living / Family Living /			
Intensive Medical Living)	Dood on charaction the Assess did not	Provider:	
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue:	Based on observation, the Agency did not ensure that each individuals' residence met all	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	requirements within the standard for 4 of 8	deficiencies cited in this tag here (How is the	
Chapter 10: Living Care Arrangements	Living Care Arrangement residences.	deficiency going to be corrected? This can be	
(LCA) 10.3.6 Requirements for Each	Living Care Arrangement residences.	specific to each deficiency cited or if possible an	
Residence: Provider Agencies must assure	Review of the residential records and	overall correction?): \rightarrow	
that each residence is clean, safe, and	observation of the residence revealed the		
comfortable, and each residence	following items were not found, not functioning		
accommodates individual daily living, social	or incomplete:		
and leisure activities. In addition, the Provider			
Agency must ensure the residence:	Supported Living Requirements:		
1. has basic utilities, i.e., gas, power, water,	- app		
and telephone.	Battery operated or electric smoke detectors		
2. has a battery operated or electric smoke	or a sprinkler system (#9)	Provider:	
detectors or a sprinkler system, carbon	()	Enter your ongoing Quality	
monoxide detectors, and fire extinguisher.	 Carbon monoxide detectors (#1, 2, 9) 	Assurance/Quality Improvement	
3. has a general-purpose first aid kit.	(, , , ,	processes as it related to this tag number	
4. has accessible written documentation of	 Poison Control Phone Number (#2, 5) 	here (What is going to be done? How many	
evacuation drills occurring at least three times	(individuals is this going to affect? How often will this be completed? Who is responsible? What	
a year overall, one time a year for each shift.	 General-purpose first aid kit (#9) 	steps will be taken if issues are found?): →	
5. has water temperature that does not	, ,	la contra de la contra del la contra del la contra del la contra de la contra de la contra del la contra de la contra del l	
exceed a safe temperature (110 ⁰ F).			
6. has safe storage of all medications with			
dispensing instructions for each person that			
are consistent with the Assistance with			
Medication (AWMD) training or each person's			
ISP.			
7. has an emergency placement plan for			
relocation of people in the event of an			
emergency evacuation that makes the			
residence unsuitable for occupancy.			
8. has emergency evacuation procedures			
that address, but are not limited to, fire,			
chemical and/or hazardous waste spills, and			
flooding.			
9. supports environmental modifications and			
assistive technology devices, including			
modifications to the bathroom (i.e., shower			
chairs, grab bars, walk in shower, raised			1

	toilets, etc.) based on the unique needs of the individual in consultation with the IDT. 10. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed. 11. has the phone number for poison control within line of site of the telephone. 12. has general household appliances, and kitchen and dining utensils. 13. has proper food storage and cleaning supplies. 14. has adequate food for three meals a day and individual preferences: and 15. has at least two bathrooms for residences with more than two residents.			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
		that claims are coded and paid for in accordance w	rith the
reimbursement methodology specified in the app			
Tag # IS25 Community Integrated	Standard Level Deficiency		
Employment Services	Daniel and the daniel Plant	Describing	
Developmental Disabilities (DD) Waiver	Based on record review, the Agency did not	Provider:	
Service Standards 2/26/2018; Re-Issue:	provide written or electronic documentation as	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	evidence for each unit billed for Supported	deficiencies cited in this tag here (How is the	
Chapter 21: Billing Requirements: 21.4	Employment Services for 5 or 8 individuals	deficiency going to be corrected? This can be specific to each deficiency cited or if possible an	
Recording Keeping and Documentation	In this internal 110	overall correction?): →	
Requirements: DD Waiver Provider Agencies	Individual #2	overall correction:).	
must maintain all records necessary to	September 2021		
demonstrate proper provision of services for	The Agency billed 1 units of Community		
Medicaid billing. At a minimum, Provider	Integrated Employment Services (T2025		
Agencies must adhere to the following:	HB-UA) on 9/3/2021. Documentation		
1. The level and type of service provided	received accounted for .5 units.		
must be supported in the ISP and have an			
approved budget prior to service delivery and	Individual #7	Provider:	
billing.	September 2021	Enter your ongoing Quality	
2. Comprehensive documentation of direct	The Agency billed 1 unit of Community	Assurance/Quality Improvement	
service delivery must include, at a minimum:	Integrated Employment Services (T2025	processes as it related to this tag number	
a. the agency name.	HB-UA) on 9/1/2021. No documentation	here (What is going to be done? How many	
b. the name of the recipient of the service. c. the location of theservice.	was found on 9/1/2021 to justify the 1 unit	individuals is this going to affect? How often will	
d. the location of theservice.	billed.	this be completed? Who is responsible? What	
e. the type of service.	O-t-10004	steps will be taken if issues are found?): →	
f. the start and end times of theservice.	October 2021		
g. the signature and title of each staff member	The Agency billed 1 unit of Community The Agency bi		
who documents their time; and	Integrated Employment Services (T2025		
h. the nature of services.	HB-UA) on 10/6/2021. No documentation		
A Provider Agency that receives payment	was found on 10/6/2021 to justify the 1 unit		
for treatment, services, or goods must retain all	billed.		
medical and business records for a period of at	Newspaper 2004		
least six years from the last payment date, until	November 2021		
ongoing audits are settled, or until involvement	The Agency billed 1 unit of Community The Agency billed 1 unit of Community		
of the state Attorney General is completed	Integrated Employment Services (T2025		
regarding settlement of any claim, whichever is	HB-UA) on 11/3/2021. No documentation		
longer.	was found on 11/3/2021 to justify the 1 unit		
4. A Provider Agency that receives payment	billed.		
for treatment, services or goods must retain all	In all induced #444		
medical and business records relating to any of	Individual #11		
the following for a period of at least six years	September 2021		
, , ,	of Findings Advantage Communications System Inc		

from the payment date:

- a. treatment or care of any eligible recipient.
- b. services or goods provided to any eligible recipient.
- c. amounts paid by MAD on behalf of any 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.

 The Agency billed 1 unit of Community Integrated Employment Services (T2025 HB-UA) on 9/1/2021. Documentation received accounted for .5 units.

October 2021

 The Agency billed 1 unit of Community Integrated Employment Services (T2025 HB-UA) on 10/6/2021. Documentation received accounted for .5 units.

November 2021

 The Agency billed 1 unit of Community Integrated Employment Services (T2025 HB-UA) on 11/3/2021. Documentation received accounted for .5 units.

Individual #12 September 2021

 The Agency billed 1 unit of Community Integrated Employment Services (T2025 HB-UA) on 9/1/2021. Documentation received accounted for .75 units.

October 2021

 The Agency billed 1 unit of Community Integrated Employment Services (T2025 HB-UA) on 10/6/2021. Documentation received accounted for .75 units.

November 2021

 The Agency billed 1 unit of Community Integrated Employment Services (T2025 HB-UA) on 11/3/2021. Documentation received accounted for .75 units.

Individual #16 September 2021

 The Agency billed 1 unit of Community Integrated Employment Services (T2025 HB-UA) on 9/3/2021. No documentation

- 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 billed.
- 3. Monthly units can be prorated by a half unit.
- 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.
- **21.9.3** Requirements for 15-minute and hourly units: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:
- 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.
- 2. Services that last in their entirety less than eight minutes cannot be billed.

was found on 9/3/2021 to justify the 1 unit billed.

October 2021

 The Agency billed 1 unit of Community Integrated Employment Services (T2025 HB-UA) on 10/7/2021. No documentation was found on 10/7/2021 to justify the 1 unit billed.

November 2021

 The Agency billed 1 unit of Community Integrated Employment Services (T2025 HB-UA) on 11/3/2021. No documentation was found on 11/3/2021 to justify the 1 unit billed.

Tag # IS30 Customized Community	Standard Level Deficiency		
Supports Reimbursement	,		
Developmental Disabilities (DD) Waiver	Based on record review, the Agency did not	Provider:	
Service Standards 2/26/2018; Re-Issue:	provide written or electronic documentation as	State your Plan of Correction for the	
12/28/2018; Eff 1/1/2019	evidence for each unit billed for Customized	deficiencies cited in this tag here (How is the	
Chapter 21: Billing Requirements: 21.4	Community Supports for 9 of 16 individuals.	deficiency going to be corrected? This can be	
Recording Keeping and Documentation		specific to each deficiency cited or if possible an	
Requirements: DD Waiver Provider Agencies	Individual #1	overall correction?): →	
must maintain all records necessary to	September 2021		
demonstrate proper provision of services for	The Agency billed 132 units of Customized		
Medicaid billing. At a minimum, Provider	Community Supports Individual Intensive		
Agencies must adhere to the following:	Behavioral Services (H2021 HB-TG) from		
The level and type of service	9/12/2021 through 9/15/2021. No		
provided must be supported in the	documentation was found for 9/12/2021		
ISP and have an approved budget	through 9/15/2021 to justify the 132 units	B	
prior to service delivery and billing.	billed.	Provider:	
Comprehensive documentation of direct		Enter your ongoing Quality	
service delivery must include, at a minimum:	The Agency billed 228 units of Customized	Assurance/Quality Improvement	
a. the agency name.	Community Supports Individual Intensive	processes as it related to this tag number	
b. the name of the recipient of the service.	Behavioral Services (H2021 HB-TG) from	here (What is going to be done? How many individuals is this going to affect? How often will	
c. the location of theservice.	9/17/2021 through 9/24/2021.	this be completed? Who is responsible? What	
d. the date of the service.	Documentation did not contain the	steps will be taken if issues are found?): \rightarrow	
e. the type of service.	required elements on 9/17/2021 through		
f. the start and end times of theservice.	9/24/2021. Documentation received		
g. the signature and title of each staff	accounted for 0 units. The required		
member who documents their time; and	element was not met:		
h. the nature of services.	Services were provided concurrently		
3. A Provider Agency that receives payment	with another service		
for treatment, services, or goods must retain			
all medical and business records for a period	The Agency billed 104 units of Customized		
of at least six years from the last payment	Community Supports Individual Intensive		
date, until ongoing audits are settled, or until	Behavioral Services (H2021 HB-TG) from		
involvement of the state Attorney General is	9/26/2021 through 9/28/2021.		
completed regarding settlement of any claim,	Documentation did not contain the		
whichever is longer.	required elements on 9/26/2021 through		
4. A Provider Agency that receives payment	9/28/2021. Documentation received		
for treatment, services or goods must retain all	accounted for 0 units. The required		
medical and business records relating to any	element was not met:		
of the following for a period of at least six	Services were provided concurrently		
years from the payment date:	with another service		
a. treatment or care of any eligible			
recipient.	October 2021		
b. services or goods provided to any			

- eligible recipient.
- c. amounts paid by MAD on behalf of any 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:

- The Agency billed 104 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 10/3/2021 through 10/5/2021.
 Documentation received accounted for 82 units.
- The Agency billed 104 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 10/10/2021 through 10/12/2021.
 Documentation did not contain the required elements on 10/10/2021 through 10/12/2021. Documentation received accounted for 74 units. The required element was not met:
 - Services were provided concurrently with another service
- The Agency billed 495.36 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 10/18/2021 through 10/19/2021. Documentation received accounted for 74 units.
- The Agency billed 104 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 10/24/2021 through 10/26/2021.
 Documentation did not contain the required elements on 10/24/2021 through 10/26/2021. Documentation received accounted for 96 units. The required element was not met:
 - Services were provided concurrently with another service
- The Agency billed 48 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) on

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- 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 billed.
- 3. Monthly units can be prorated by a half unit.
- 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.
- **21.9.3** Requirements for 15-minute and hourly units: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:
- 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.
- 2. Services that last in their entirety less than eight minutes cannot be billed.

- 10/31/2021. Documentation did not contain the required elements on 10/31/2021. Documentation received accounted for 0 units. The required element was not met:
- Services were provided concurrently with another service

November 2021

- The Agency billed 56 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 11/1/2021 through 11/2/2021.
 Documentation did not contain the required elements on 11/1/2021 through 11/2/2021. Documentation received accounted for 28 units. The required element was not met:
 - Services were provided concurrently with another service
- The Agency billed 132 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 11/22/2021 through 11/30/2021.
 Documentation did not contain the required elements on 11/22/2021 through 11/30/2021. Documentation received accounted for 114 units. The required element was not met:
 - Services were provided concurrently with another service

Individual #2

November 2021

 The Agency billed 53 units of Customized Community Supports Individual (H2021 HB-U1) from 11/15/2021 through 11/19/2021. Documentation received accounted for 51 units.

Individual #6 September 2021

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 The Agency billed 96 units of Customized Community Supports Individual (H2021 HB-U1) from 9/27/2021 through 9/30/2021. No documentation was found for 9/27/2021 through 9/30/2021 to justify the 96 units billed.

October 2021

- The Agency billed 24 units of Customized Community Supports Individual (H2021 HB-U1) on 10/1/2021. No documentation was found for 10/1/2021 to justify the 24 units billed.
- The Agency billed 61 units of Customized Community Supports Individual (H2021 HB-U1) from 10/5/2021 through 10/8/2021. Documentation received accounted for 57 units.

Individual #7 September 2021

 The Agency billed 110 units of Customized Community Supports Individual (H2021 HB-U1) from 9/9/2021 through 9/13/2021. Documentation received accounted for 96 units.

October 2021

 The Agency billed 127 units of Customized Community Supports Individual (H2021 HB-U1) from 10/11/2021 through 10/15/2021. Documentation received accounted for 126 units.

November 2021

 The Agency billed 72 units of Customized Community Supports Individual (H2021 HB-U1) from 11/22/2021 through 11/26/2021. Documentation received accounted for 68 units.

Individual #9 September 2021 • The Agency billed 121 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 9/1/2021 through 9/3/2021. Documentation did not contain the required elements on 9/1/2021 through 9/3/2021. Documentation received accounted for 94 units. The required element was not met: ➤ Services were provided concurrently with another service	
 The Agency billed 159 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 9/8/2021 through 9/10/2021. Documentation did not contain the required elements on 9/8/2021 through 9/10/2021. Documentation received accounted for 86 units. The required element was not met: ➢ Services were provided concurrently with another service 	
 The Agency billed 121 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 9/22/2021 through 9/24/2021. Documentation did not contain the required elements on 9/22/2021 through 9/24/2021. Documentation received accounted for 93 units. The required element was not met: ➢ Services were provided concurrently with another service 	
 The Agency billed 80 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 9/29/2021 through 9/30/2021. 	

Documentation did not contain the required elements on 9/29/2021 through 9/30/2021. Documentation received accounted for 48 units. The required element was not met: > Services were provided concurrently with another service	
October 2021 • The Agency billed 93 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 10/6/2021 through 10/8/2021. Documentation did not contain the required elements on 10/6/2021 through 10/8/2021. Documentation received accounted for 85 units. The required element was not met: ➤ Services were provided concurrently with another service	
The Agency billed 132 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 10/11/2021 through 10/15/2021. Documentation did not contain the required elements on 10/11/2021 through 10/15/2021. Documentation received accounted for 55 units. The required element was not met: Services were provided concurrently with another service	
The Agency billed 120 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 10/18/2021 through 10/22/2021. Documentation did not contain the required elements on 10/18/2021 through 10/22/2021. Documentation received	

accounted for 108 units. The required

element was not met:

Services were provided concurrently with another service	
The Agency billed 124 units of Customized Community Supports Individual Intensive Behavioral Services (H2021 HB-TG) from 10/25/2021 through 10/29/2021. Documentation did not contain the required elements on 10/25/2021 through 10/29/2021. Documentation received accounted for 122 units. The required element was not met: Services were provided concurrently with another service	
Individual #12 November 2021 • The Agency billed 112 units of Customized Community Supports Individual (H2021 HB-U1) from 11/8/2021 through 11/12/2021. Documentation received accounted for 90 units.	
Individual #13 October 2021 • The Agency billed 118 units of Customized Community Supports Individual (H2021 HB-U1) from 10/21/2021 through 10/23/2021. Documentation received accounted for 116 units.	
November 2021 • The Agency billed 32 units of Customized Community Supports Individual (H2021 HB-U1) on 11/28/2021. Documentation received accounted for 16 units.	
Individual #16 September 2021	

• The Agency billed 119 units of Customized Community Supports Individual (H2021 HB-U1) from 9/20/2021 through 9/24/2021.

Documentation received accounted for 118 units.	
 The Agency billed 113 units of Customized Community Supports Individual (H2021 HB-U1) from 9/27/2021 through 9/30/2021. Documentation received accounted for 94 units. 	
October 2021 • The Agency billed 64 units of Customized Community Supports Individual (H2021 HB-U1) from 10/4/2021 through 10/7/2021. Documentation received accounted for 60 units.	
 The Agency billed 98 units of Customized Community Supports Individual (H2021 HB-U1) from 10/11/2021 through 10/15/2021. Documentation received accounted for 97 units. 	
November 2021 • The Agency billed 101 units of Customized Community Supports Individual (H2021 HB-U1) from 11/22/2021 through 11/26/2021. Documentation received accounted for 100 units.	
Individual #17 September 2021 • The Agency billed 96 units of Customized Community Supports Individual (H2021 HB-U1) from 9/1/2021 through 9/3/2021. Documentation received accounted for 48 units.	
The Agency billed 142 units of Customized Community Supports Individual (H2021 HB-U1) from 9/7/2021 through 9/11/2021. Documentation received accounted for 63 units.	

units.

The Agency billed 128 units of Customized Community Supports Individual (H2021 HB-U1) from 9/13/2021 through 9/18/2021. Documentation received accounted for 96 units.	
 The Agency billed 124 units of Customized Community Supports Individual (H2021 HB-U1) from 9/20/2021 through 9/24/2021. Documentation received accounted for 56 units. 	
October 2021 • The Agency billed 139 units of Customized Community Supports Individual (H2021 HB-U1) from 10/4/2021 through 10/8/2021. Documentation received accounted for 75 units.	
The Agency billed 76 units of Customized Community Supports Individual (H2021 HB-U1) from 10/19/2021 through 10/21/2021. Documentation received accounted for 24 units.	
 The Agency billed 79 units of Customized Community Supports Individual (H2021 HB-U1) from 10/26/2021 through 10/29/2021. Documentation received accounted for 56 units. 	

Tag # LS26 Supported Living	Standard Lovel Deficiency		
Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements: 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:	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 12 of 18 individuals. Individual #1 September 2021 • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 9/1/2021.	Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →	
 The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. Comprehensive documentation of direct service delivery must include, at a minimum: the agency name. the name of the recipient of the service. the location of theservice. the type of service. the start and end times of theservice. the signature and title of each staff member who documents their time; and h. the nature of services. 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. 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	 Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 7.5 hours, which is less and the required amount. The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 9/26/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 7 hours, which is less and the required amount. The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 9/29/2021. No Documentation was found for 9/29/2021 to justify the 1 unit billed. The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 9/30/2021. No Documentation was found for 9/30/2021 to justify the 1 unit billed. 	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →	
years from the payment date: a. treatment or care of any eligible recipient. b. services or goods provided to any	October 2021		
		1	1

- eligible recipient.
- c. amounts paid by MAD on behalf of any 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

 The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 10/1/2021.
 Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 4.5 hours, which is less and the required amount.

November 2021

- The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 11/1/2021.
 Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less and the required amount.
- The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 11/29/2021.
 Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less and the required amount.
- The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 11/30/2021.
 Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less and the required amount.

Individual #2

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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 billed.
- 3. Monthly units can be prorated by a half unit.
- 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.
- **21.9.3** Requirements for **15-minute** and **hourly units**: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:
- 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.
- 2. Services that last in their entirety less than eight minutes cannot be billed.

September 2021

- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/4/2021.
 Documentation received accounted for 0 units. Daily note indicated Individual was "out of facility."
- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/5/2021.
 Documentation received accounted for 0 units. Daily note indicated Individual was "out of facility."
- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/6/2021.
 Documentation received accounted for 0 units. Daily note indicated Individual was "out of facility."

October 2021

- The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 10/5/2021.
 Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less and the required amount.
- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/6/2021.
 Documentation received accounted for 0 units. Daily note indicated Individual was "out of facility."
- The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 10/7/2021.
 Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a

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complete unit. Documentation received accounted for 4 hours, which is less and the required amount.	
The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 10/29/2021. Documentation received accounted for .5 units Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/30/2021. Documentation received accounted for 0 units. Daily note indicated Individual was "at parents." 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/31/2021. Documentation received accounted for 0 units. Daily note indicated Individual was "at parents." 	
November 2021 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/7/2021. Documentation received accounted for 0 units. Daily note indicated Individual was "still gone from house."	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/8/2021. Documentation received accounted for 0 units. Daily note indicated Individual was "out of facility." 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 11/9/2021. 	

Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24hour period must be provided in order to bill a complete unit. Documentation received accounted for 8.5 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/25/2021. Documentation received accounted for 0 units. Daily note indicated Individual was "out of facility." The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 11/30/2021. Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. Individual #6 November 2021 The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 11/23/2021. Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24hour period must be provided in order to bill a complete unit. Documentation received accounted for 10.5 hours, which is less than the required amount.

Individual #7 September 2021

- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/1/2021.

 Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 1 hours, which is less than the required amount.
- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/15/2021.
 Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount.

October 2021

- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/1/2021.
 Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount.
- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/2/2021.
 Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24hour period must be provided in order to bill a complete unit. Documentation

received accounted for 11 hours, which is	
less than the required amount.	
1000 than the required amount.	
The Agency billed 4 unit of Cumparted	
The Agency billed 1 unit of Supported (Toold ALP Ho)	
Living (T2016 HB-U6) on 10/5/2021.	
Documentation received accounted for .5	
units. Documentation received accounted	
for .5 units. As indicated by the DDW	
Standards more than 12 hours in a 24-	
hour period must be provided in order to	
bill a complete unit. Documentation	
received accounted for 10 hours, which is	
less than the required amount.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 10/9/2021.	
Documentation received accounted for .5	
units. Documentation received accounted	
for .5 units. As indicated by the DDW	
Standards more than 12 hours in a 24-	
hour period must be provided in order to	
bill a complete unit. Documentation	
received accounted for 8 hours, which is	
less than the required amount.	
γ	
 The Agency billed 1 unit of Supported 	
Living (T2016 HB-U6) on 10/10/2021.	
Documentation received accounted for .5	
units. Documentation received accounted	
for .5 units. As indicated by the DDW	
Standards more than 12 hours in a 24-	
hour period must be provided in order to	
bill a complete unit. Documentation	
received accounted for 11 hours, which is	
less than the required amount.	
 The Agency billed 1 unit of Supported 	
Living (T2016 HB-U6) on 10/11/2021.	
Documentation received accounted for .5	
units. Documentation received accounted	
for .5 units. As indicated by the DDW	
Standards more than 12 hours in a 24-	
Standards more than 12 hours in a 24-	

hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount.	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/12/2021. Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 1 hours, which is less than the required amount.	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/14/2021. Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount.	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/20/2021. Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/21/2021. Documentation received accounted for .5 units. Documentation received accounted 	

for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 1 hours, which is less than the required amount.	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/25/2021. Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount.	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/26/2021. Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount.	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/27/2021. Documentation received accounted for .5 units. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/28/2021. No 	

to just The A Living Documents for .5 Stand hour bill a recei	mentation was found for 10/28/2021 tify the 1 unit billed. Agency billed 1 unit of Supported g (T2016 HB-U6) on 10/29/2021. Imentation received accounted for .5. Documentation received accounted units. As indicated by the DDW dards more than 12 hours in a 24-period must be provided in order to complete unit. Documentation ved accounted for 4 hours, which is than the required amount.	
Living Docu units for .5 Stand hour bill a recei	Agency billed 1 unit of Supported g (T2016 HB-U6) on 11/5/2021. Immentation received accounted for .5 In Documentation received accounted a units. As indicated by the DDW dards more than 12 hours in a 24-period must be provided in order to complete unit. Documentation accounted for 11 hours, which is than the required amount.	
Living Docu units for .5 Stand hour bill a recei	Agency billed 1 unit of Supported g (T2016 HB-U6) on 11/24/2021. Immentation received accounted for .5. Documentation received accounted units. As indicated by the DDW dards more than 12 hours in a 24-period must be provided in order to complete unit. Documentation ved accounted for 10 hours, which is than the required amount.	
Individua Septemb		

 The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 9/29/2021.

Documentation received accounted fo units. Individual was hospitalized.	r .5
The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 9/30/2021. Documentation received accounted fo units. Individual was hospitalized.	r 0
October 2021 • The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 10/1/2021. Documentation received accounted fo units. Individual was hospitalized.	r 0
The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 10/2/2021. Documentation received accounted fo units. Individual was hospitalized.	r 0
The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 10/3/2021. Documentation received accounted fo units. Individual was hospitalized.	r 0
The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 10/4/2021. Documentation received accounted fo units. Individual was hospitalized.	r 0
The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 10/5/2021. Documentation received accounted fo units. Individual was hospitalized.	r 0
The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 10/6/2021. Documentation received accounted fo units. Individual was hospitalized.	r 0
November 2021 • The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 11/1/2021.	

Documentation received accounted for units. Individual was hospitalized.	0
The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 11/2/2021. Documentation received accounted for units. Individual was hospitalized.	0
Individual #9 September 2021 • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/1/2021. Documentation did not contain the required elements on 9/1/2021. Documentation received accounted for units. The required elements were not met: ▶ The signature or authenticated nam of staff providing the service.	
Services were provided concurrently with another service.	y
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/2/2021. Documentation did not contain the required elements on 9/2/2021. Documentation received accounted for units. The required elements were not met: ➤ The signature or authenticated name of staff providing the service; 	
 Services were provided concurrently with another service. 	y
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/3/2021. Documentation did not contain the required elements on 9/3/2021. Documentation received accounted for	0

The signature or authenticated name of staff providing the service.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/4/2021. Documentation did not contain the required elements on 9/4/2021. Documentation received accounted for 0 units. The required elements were not met: The signature or authenticated name of staff providing the service. 	
Services were provided concurrently with another service.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/5/2021. Documentation did not contain the required elements on 9/5/2021. Documentation received accounted for 0 units. The required element was not met: ➤ The signature or authenticated name of staff providing the service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/6/2021. Documentation did not contain the required elements on 9/6/2021. Documentation received accounted for .5 units. The required elements were not met: The signature or authenticated name of staff providing the service. 	
Services were provided concurrently with another service.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/7/2021. Documentation did not contain the required elements on 9/7/2021. 	

Documentation received accounted for .5 units. The required element was not met: Services were provided concurrently with another service.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/8/2021. Documentation did not contain the required elements on 9/8/2021. Documentation received accounted for 0 units. The required elements were not met: The signature or authenticated name of staff providing the service. 	
Services were provided concurrently with another service.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/9/2021. Documentation did not contain the required elements on 9/9/2021. Documentation received accounted for .5 units. The required element was not met: ➢ Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/10/2021. Documentation did not contain the required elements on 9/10/2021. Documentation received accounted for 0 units. The required element was not met: ➢ Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/11/2021. Documentation did not contain the required elements on 9/11/2021. Documentation received accounted for .5 units. The required element was not met: 	

Services were provided concurrently	
with another service.	
 The Agency billed 1 unit of Supported 	
Living (T2016 HB-U6) on 9/12/2021.	
Documentation did not contain the	
required elements on 9/12/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
Services were provided concurrently	
with another service.	
 The Agency billed 1 unit of Supported 	
Living (T2016 HB-U6) on 9/13/2021.	
Documentation did not contain the	
required elements on 9/13/2021.	
Documentation received accounted for 0	
units. The required element was not met:	
Services were provided concurrently	
with another service.	
 The Agency billed 1 unit of Supported 	
Living (T2016 HB-U6) on 9/14/2021.	
Documentation did not contain the	
required elements on 9/14/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
 Services were provided concurrently 	
with another service.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 9/15/2021.	
Documentation did not contain the	
required elements on 9/15/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
Services were provided concurrently	
with another service.	
 The Agency billed 1 unit of Supported 	
Living (T2016 HB-U6) on 9/16/2021.	
Documentation did not contain the	

units. The required e ➤ Services were pre with another serv	elived accounted for .5 element was not met: rovided concurrently vice.
	6) on 9/17/2021. not contain the n 9/17/2021. vived accounted for .5 element was not met: rovided concurrently
	6) on 9/18/2021. not contain the n 9/18/2021. vived accounted for .5 element was not met: rovided concurrently
	6) on 9/19/2021. not contain the n 9/19/2021. vived accounted for .5 element was not met: rovided concurrently
	6) on 9/20/2021. not contain the n 9/20/2021. vived accounted for .5 element was not met: rovided concurrently

 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/21/2021. Documentation did not contain the required elements on 9/21/2021. Documentation received accounted for .5 units. The required element was not met: Services were provided concurrently with another service. 	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/22/2021. Documentation did not contain the required elements on 9/22/2021. Documentation received accounted for .5 units. The required element was not met: ▶ Services were provided concurrently with another service.	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/23/2021. Documentation did not contain the required elements on 9/23/2021. Documentation received accounted for .5 units. The required element was not met: ▶ Services were provided concurrently with another service.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/24/2021. Documentation did not contain the required elements on 9/24/2021. Documentation received accounted for 0 units. The required element was not met: Services were provided concurrently with another service. 	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/25/2021. Documentation did not contain the required elements on 9/25/2021. Documentation received accounted for .5	

➤ The signature or authenticated name	
of staff providing the service.	
5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5	
The Agency billed 1 units of Supported	
Living (T2016 HB-U6) from on 9/26/2021.	
Documentation did not contain the	
required elements on 9/26/2021.	
Documentation received accounted for 0	
units. The required element was not met:	
➤ The signature or authenticated name	
of staff providing the service.	
of stall providing the service.	
The Agency billed 1 unit of Cupported	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/27/2021.	
Documentation did not contain the	
required elements on 9/27/2021.	
· ·	
Documentation received accounted for 0	
units. The required element was not met:	
Services were provided concurrently	
with another service.	
The Agency hilled 4 weit of Comparted	
The Agency billed 1 unit of Supported Figure (Toole LIB LIS) True (100) True (100)	
Living (T2016 HB-U6) on 9/28/2021.	
Documentation did not contain the	
required elements on 9/28/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
Services were provided concurrently	
with another service.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 9/29/2021.	
Documentation did not contain the	
required elements on 9/29/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
➤ The signature or authenticated name	
of staff providing the service.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 9/30/2021.	
Documentation did not contain the	

required elements on 9/30/2021. Documentation received accounted for .5 units. The required element was not met: > The signature or authenticated name of staff providing the service. October 2021 • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/1/2021. Documentation did not contain the required elements on 10/1/2021. Documentation received accounted for .5 units. The required element was not met: Services were provided concurrently with another service. The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/2/20214. Documentation did not contain the required elements on 10/2/2021. Documentation received accounted for 0 units. The required element was not met: > Services were provided concurrently with another service. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/3/2021. Documentation did not contain the required elements on 10/3/20214. Documentation received accounted for 0 units. The required element was not met: Services were provided concurrently with another service. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/4/2021. Documentation did not contain the required elements on 10/4/20214. Documentation received accounted for .5 units. The required element was not met:

Services were provided concurrently

with another service.

 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/5/2021. Documentation did not contain the required elements on 10/5/2021. Documentation received accounted for .5 units. The required element was not met: ➤ Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/6/2021. Documentation did not contain the required elements on 10/6/2021. Documentation received accounted for .5 units. The required element was not met: Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/7/2021. Documentation did not contain the required elements on 10/7/2021. Documentation received accounted for .5 units. The required element was not met: Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/8/2021. Documentation did not contain the required elements on 10/8/2021. Documentation received accounted for 0 units. The required element was not met: Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/9/2021. Documentation did not contain the required elements on 10/9/2021. 	

Documentation received accounted for .5

 units. The required elements were not met: Date, start and end time of each service encounter or other billable service interval. 	
Services were provided concurrently with another service.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/10/2021. Documentation did not contain the required elements on 10/10/2021. Documentation received accounted for .5 units. The required element was not met: ➢ Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/11/2021. Documentation did not contain the required elements on 10/11/2021. Documentation received accounted for .5 units. The required element was not met: ➤ Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/12/2021. Documentation did not contain the required elements on 10/12/2021. Documentation received accounted for .5 units. The required element was not met: ➤ Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/13/2021. Documentation did not contain the required elements on 10/13/2021. Documentation received accounted for .5 units. The required element was not met: 	

Services were provided concurrently with another service.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/14/2021. Documentation did not contain the required elements on 10/14/2021. Documentation received accounted for .5 units. The required element was not met: ➤ Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/15/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours which is less than the required amount. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/16/2021. Documentation did not contain the required elements on 10/16/2022. Documentation received accounted for .5 units. The required element was not met: ➤ Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/17/2021. Documentation did not contain the required elements on 10/17/2021. Documentation received accounted for .5 units. The required element was not met: Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/18/2021. 	

	Documentation did not contain the required elements on 10/18/2021. Documentation received accounted for .5 units. The required element was not met: Services were provided concurrently with another service.	
•	The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/19/2021. Documentation did not contain the required elements on 10/19/2021. Documentation received accounted for .5 units. The required element was not met: Services were provided concurrently with another service.	
•	The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/20/2021. Documentation did not contain the required elements on 10/20/2021. Documentation received accounted for .5 units. The required elements were not met: Date, start and end time of each service encounter or other billable service interval.	
	Services were provided concurrently with another service.	
	The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/21/2021. Documentation did not contain the required elements on 10/21/2021. Documentation received accounted for 0 units. The required element was not met: Services were provided concurrently with another service.	
•	The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/22/2021. Documentation did not contain the	

required elements on 10/22/202 Documentation received accou units. The required element wa > Services were provided con with another service.	nted for .5 as not met: currently
The Agency billed 1 unit of Sup Living (T2016 HB-U6) on 10/23 Documentation did not contain required elements on 10/23/202 Documentation received accountits. The required was not me ➤ Services were provided con with another service.	7/2021. the 21. nted for .5 et:
The Agency billed 1 unit of Sup Living (T2016 HB-U6) on 10/24 Documentation did not contain required elements on 10/24/202 Documentation received accountis. The required element was ➤ Services were provided conwith another service.	/2021. the 21. nted for .5 as not met:
The Agency billed 1 unit of Sup Living (T2016 HB-U6) on 10/25 Documentation did not contain required elements on 10/25/202 Documentation received accountits. The required element was ➤ Services were provided conwith another service.	/2021. the 21. nted for .5 as not met:
The Agency billed 1 unit of Sup Living (T2016 HB-U6) on 10/26 Documentation did not contain required elements on 10/26/202 Documentation received accountits. The required element was ➤ Services were provided conwith another service.	7/2021. the 21. nted for .5 as not met:

The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/27/2021. Documentation did not contain the required elements on 10/27/2021. Documentation received accounted for .5 units. The required element was not met: ➤ Services were provided concurrently with another service.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/28/2021. Documentation did not contain the required elements on 10/28/2021. Documentation received accounted for .5 units. The required element was not met: Services were provided concurrently with another service. 	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/29/2021. Documentation did not contain the required elements on 10/29/2021. Documentation received accounted for .5 units. The required element was not met: ➤ Services were provided concurrently with another service.	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/30/2021. Documentation did not contain the required elements on 10/30/2021. Documentation received accounted for .5 units. The required element was not met: ▶ Services were provided concurrently with another service.	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/31/2021. Documentation did not contain the required elements on 10/31/2021. Documentation received accounted for .5 units. The required element was not met.	

➤ Services were provided concurrently	
with another service.	
November 2021	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/1/2021.	
Documentation did not contain the	
required elements on 11/1/2021.	
Documentation received accounted for .5 units. The required element was not met:	
> Services were provided concurrently	
with another service.	
The Agency billed 1 unit of Suppo1ted	
Living (T2016 HB-U6) on 11/2/2021.	
Documentation did not contain the	
required elements on 11/2/2021.	
Documentation received accounted for .5 units. The required element was not met:	
> Services were provided concurrently	
with another service.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/3/2021.	
Documentation did not contain the	
required elements on 11/3/2021. Documentation received accounted for .5	
units. The required element was not met:	
➤ Services were provided concurrently	
with another service.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/4/2021.	
Documentation did not contain the	
required elements on 11/4/2021. Documentation received accounted for .5	
units. The required element was not met:	
Services were provided concurrently	
with another service.	
The Agency billed 1 unit of Supported	
Living (billing code and modifier) on	

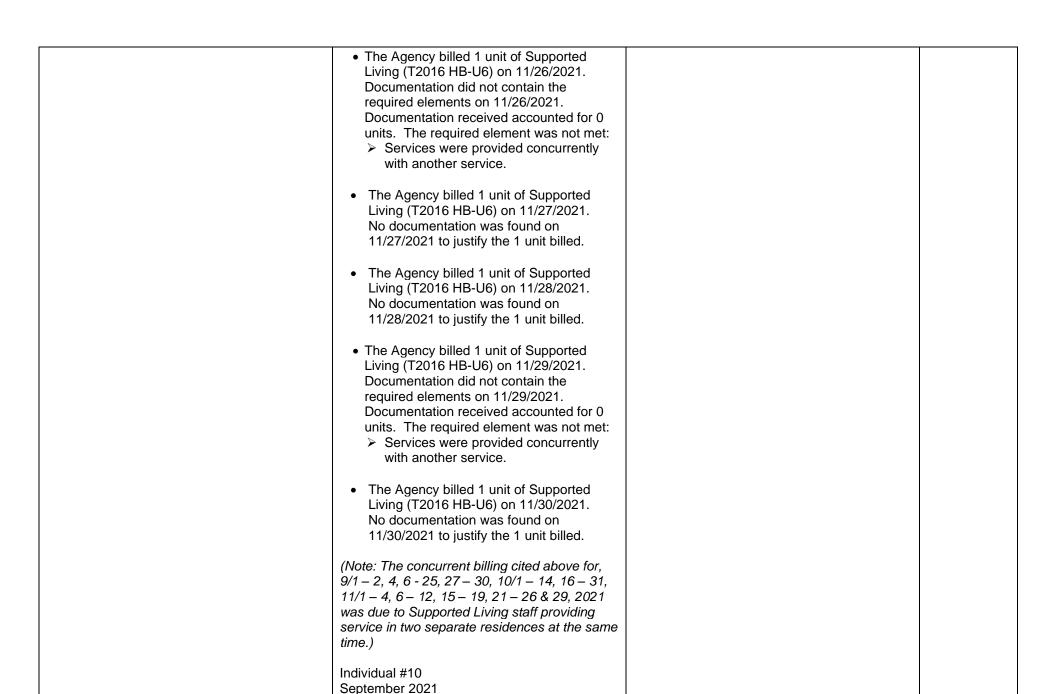
11/5/2021. No documentation was found on 11/5/2021 to justify the 1 unit billed.	
on 11/3/2021 to justify the 1 unit billed.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/6/2021.	
Documentation did not contain the required elements on 11/6/2021.	
Documentation received accounted for 0	
units. The required element was not met:	
Services were provided concurrently	
with another service.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/7/2021.	
Documentation did not contain the	
required elements on 11/7/2021.	
Documentation received accounted for 0 units. The required element was not met:	
➤ Services were provided concurrently	
with another service.	
The Assess 1 21 - 14 - 22 - 40 - 22 - 40	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/8/2021.	
Documentation did not contain the	
required elements on 11/8/2021.	
Documentation received accounted for 0	
units. The required element was not met:	
Services were provided concurrently with another service.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/9/2021.	
Documentation did not contain the required elements on 11/9/2021.	
Documentation received accounted for 0	
units. The required element was not met:	
Services were provided concurrently	
with another service.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/10/2021.	
Documentation did not contain the	

required elements on 11/10/2021. Documentation received accounted for 0 units. The required element was not met: Services were provided concurrently with another service.		
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/11/2021. Documentation did not contain the required elements on 11/12/2021. Documentation received accounted for 0 units. The required element was not met: ➤ Services were provided concurrently with another service. 		
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/12/2021. Documentation did not contain the required elements on 11/12/2021. Documentation received accounted for 0 units. The required element was not met: Services were provided concurrently with another service. 		
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/13/2021. No documentation was found on 11/13/2021 to justify the 1 units billed. 		
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/14/2021. No documentation was found on 11/14/2021 to justify the 1 units billed. 		
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/15/2021. Documentation did not contain the required elements on 11/15/2021. Documentation received accounted for 0 units. The required element was not met: Services were provided concurrently 		
	Documentation received accounted for 0 units. The required element was not met: ➤ Services were provided concurrently with another service. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/11/2021. Documentation did not contain the required elements on 11/12/2021. Documentation received accounted for 0 units. The required element was not met: ➤ Services were provided concurrently with another service. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/12/2021. Documentation did not contain the required elements on 11/12/2021. Documentation received accounted for 0 units. The required element was not met: ➤ Services were provided concurrently with another service. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/13/2021. No documentation was found on 11/13/2021 to justify the 1 units billed. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/14/2021. No documentation was found on 11/14/2021 to justify the 1 units billed. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/15/2021. Documentation did not contain the required elements on 11/15/2021. Documentation received accounted for 0 units. The required element was not met:	Documentation received accounted for 0 units. The required element was not met: > Services were provided concurrently with another service. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/11/2021. Documentation did not contain the required elements on 11/12/2021. Documentation received accounted for 0 units. The required element was not met: > Services were provided concurrently with another service. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/12/2021. Documentation did not contain the required elements on 11/12/2021. Documentation received accounted for 0 units. The required element was not met: > Services were provided concurrently with another service. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/13/2021. No documentation was found on 11/13/2021 to justify the 1 units billed. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/14/2021. No documentation was found on 11/14/2021 to justify the 1 units billed. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/14/2021. No documentation was found on 11/14/2021 to justify the 1 units billed. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/15/2021. Documentation did not contain the required elements on 11/15/2021. Documentation received accounted for 0 units. The required element was not met: > Services were provided concurrently

The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/16/2021. Documentation did not contain the required elements on 11/16/2021. Documentation received accounted for 0 units. The required element was not met: ▶ Services were provided concurrently with another service.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/17/2021. Documentation did not contain the required elements on 11/17/2021. Documentation received accounted for 0 units. The required element was not met: ➤ Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/18/2021. Documentation did not contain the required elements on 11/18/2021. Documentation received accounted for 0 units. The required element was not met: ➤ Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/19/2021. Documentation did not contain the required elements on 11/19/2021. Documentation received accounted for 0 units. The required element was not met: ➤ Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/21/2021. 	

Documentation did not contain the required elements on 11/21/2021.

Documentation received accounted for 0 units. The required element was not met: > Services were provided concurrently with another service.	
 The Agency billed 1 units of Supported Living (T2016 HB-U6) on 11/22/2021. Documentation did not contain the required elements on 11/22/2021. Documentation received accounted for 0 units. The required element was not met: ➢ Services were provided concurrently with another service 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/23/2021. Documentation did not contain the required elements on 11/23/2021. Documentation received accounted for 0 units. The required element was not met: Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/24/2021. Documentation did not contain the required elements on 11/24/2021. Documentation received accounted for 0 units. The required element was not met: ➤ Services were provided concurrently with another service. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/25/2021. Documentation did not contain the required elements on 11/25/2021. Documentation received accounted for 0 units. The required element was not met: Services were provided concurrently with another service. 	



 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/3/2021. Documentation did not contain the required elements on 9/3/2021. Documentation received accounted for .5 units. The required element was not met: ➤ A description of what occurred during the encounter or service interval. 	
 The Agency Billed 1 unit of Supported Living (T2016 HB-U6) on 9/4/2021. Documentation received accounted for 0 units. Daily note indicated Individual was "out of services." 	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/5/2021. Documentation received accounted for .5 unit. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 4 hours, which is less than the required amount.	
 The Agency Billed 1 unit of Supported Living (T2016 HB-U6) on 9/10/2021. Documentation received accounted for 0 unit. Daily note indicated Individual was "out of services." 	
 The Agency Billed 1 unit of Supported Living (T2016 HB-U6) on 9/11/2021. Documentation received accounted for 0 unit. Daily note indicated Individual was "out of services." 	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/12/2021. Documentation received accounted for .5 units. As indicated by the DDW Consideration and the second of the s	

Standards more than 12 hours in a 24-

hour period must be provided in order to bill a complete unit. Documentation received accounted for 8.5 hours, which is less than the required amount.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/17/2021. Documentation did not contain the required elements on 9/17/2021 Documentation received accounted for .5 units. The required element was not met: ➤ A description of what occurred during the encounter or service interval. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/19/2021. Documentation did not contain the required elements on 9/19/2021 Documentation received accounted for .5 units. The required element was not met: ➤ A description of what occurred during the encounter or service interval. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/23/2021. Documentation did not contain the required elements on 9/23/2021 Documentation received accounted for .5 units. The required element was not met: ➤ A description of what occurred during the encounter or service interval. 	
 The Agency Billed 1 unit of Supported Living (T2016 HB-U6) on 9/24/2021. Documentation received accounted for 0 units. Daily note indicated Individual was "out of services." 	
October 2021 • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/7/2021.	

Documentation received accounted for .50 unit. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount.	
 The Agency Billed 1 unit of Supported Living (T2016 HB-U6) on 10/23/2021. Documentation received accounted for 0 units. Daily note indicated Individual was "out of services." 	
November 2021 • The Agency Billed 1 unit of Supported Living (T2016 HB-U6) on 11/6/2021. Documentation received accounted for 0 units. Daily note indicated Individual was "out of services."	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/7/2021. Documentation received accounted for .5 unit. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount.	
The Agency Billed 1 unit of Supported Living (T2016 HB-U6) on 11/26/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation	

received accounted for 8 hours, which is

less than the required amount.

The Agency Billed 1 unit of Supported Living (T2016 HB-U6) on 11/27/2021. Documentation received accounted for 0 units. Daily note indicated Individual was "out of services."	
Individual #11 September 2021 • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/1/2021. Documentation did not contain the required elements on 9/1/2021. Documentation received accounted for .5 units. The required element was not met: ➤ A description of what occurred during the encounter or service interval.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/9/2021. Documentation did not contain the required elements on 9/9/2021. Documentation received accounted for .5 units. The required element was not met: A description of what occurred during the encounter or service interval. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/10/2021. Documentation did not contain the required elements on 9/10/2021. Documentation received accounted for .5 units. The required element was not met: A description of what occurred during the encounter or service interval. 	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/11/2021. Documentation did not contain the required elements on 9/11/2021.	

Documentation received accounted for .5 units. The required element was not met:

A description of what occurred during	
the encounter or service interval.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 9/13/2021.	
Documentation did not contain the	
required elements on 9/13/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
A description of what occurred during	
the encounter or service interval.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 9/17/2021.	
Documentation did not contain the	
required elements on 9/17/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
➤ A description of what occurred during	
the encounter or service interval.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 9/20/2021.	
Documentation did not contain the	
required elements on 9/20/2021.	
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Documentation received accounted for .5	
units. The required element was not met:	
A description of what occurred during	
the encounter or service interval.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 9/21/2021.	
Documentation did not contain the	
required elements on 9/21/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
A description of what occurred during	
the encounter or service interval.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 9/24/2021.	
Documentation did not contain the	
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required elements on 9/24/2021. Documentation received accounted for .5 units. The required element was not met: > A description of what occurred during the encounter or service interval. • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/25/2021. Documentation did not contain the required elements on 9/25/2021. Documentation received accounted for .5 units. The required element was not met: A description of what occurred during the encounter or service interval. The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/27/2021. Documentation did not contain the required elements on 9/27/2021. Documentation received accounted for .5 units. The required element was not met: > A description of what occurred during the encounter or service interval. The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/30/2021. Documentation did not contain the required elements on 9/30/2021. Documentation received accounted for .5 units. The required element was not met: A description of what occurred during the encounter or service interval. October 2021 • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/4/2021. Documentation did not contain the required elements on 10/4/2021. Documentation received accounted for .5 units. The required element was not met: > A description of what occurred during

the encounter or service interval.

The Agency billed 1 unit of Support Living (T2016 HB-U6) on 10/7/2022 Documentation did not contain the required elements on 10/7/2021. Documentation received accounted units. The required element was now A description of what occurred the encounter or service interval.	for .5 bt met:
 The Agency billed 1 unit of Support Living (T2016 HB-U6) on 10/9/2022 Documentation did not contain the required elements on 10/9/2021. Documentation received accounted units. The required element was not be A description of what occurred the encounter or service interval. 	for .5 bt met:
 The Agency billed 1 unit of Support Living (T2016 HB-U6) on 10/18/202 Documentation did not contain the required elements on 10/18/2021. Documentation received accounted units. The required element was not a description of what occurred of the encounter or service interval. 	21. I for .5 ot met:
The Agency billed 1 unit of Support Living (T2016 HB-U6) on 10/19/202 Documentation did not contain the required elements on 10/19/2021. Documentation received accounted units. The required element was now A description of what occurred the encounter or service interval.	21. I for .5 ot met: during
The Agency billed 1 unit of Support Living (T2016 HB-U6) on 10/21/2021 Documentation did not contain the	

required elements on 10/21/2021.

Documentation received accounted for .5 units. The required element was not met: > A description of what occurred during the encounter or service interval.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/23/2021. Documentation did not contain the required elements on 10/23/2021. Documentation received accounted for .5 units. The required element was not met: ➤ A description of what occurred during the encounter or service interval. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/26/2021. Documentation did not contain the required elements on 10/26/2021. Documentation received accounted for .5 units. The required element was not met: A description of what occurred during the encounter or service interval. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/28/2021. Documentation did not contain the required elements on 10/28/2021. Documentation received accounted for .5 units. The required element was not met: ➤ A description of what occurred during the encounter or service interval. 	
November 2021 • The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/1/2021. Documentation did not contain the required elements on 11/1/2021. Documentation received accounted for .5 units. The required element was not met: ➤ A description of what occurred during the encounter or service interval.	

 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/3/2021. Documentation did not contain the required elements on 11/3/2021. Documentation received accounted for .5 units. The required element was not met: A description of what occurred during the encounter or service interval. 	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/8/2021. Documentation did not contain the required elements on 11/8/2021. Documentation received accounted for .5 units. The required element was not met: ➤ A description of what occurred during the encounter or service interval.	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/13/2021. Documentation did not contain the required elements on 11/13/2021. Documentation received accounted for .5 units. The required element was not met:	
 The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/15/2021. Documentation did not contain the required elements on 11/15/2021. Documentation received accounted for .5 units. The required element was not met: A description of what occurred during the encounter or service interval. 	
The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/16/2021. Documentation did not contain the required elements on 11/16/2021. Documentation received accounted for .5	

A description of what occurred during	
the encounter or service interval.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/18/2021.	
Documentation did not contain the	
required elements on 11/18/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
A description of what occurred during	
the encounter or service interval.	
the chooding of service interval.	
The Agency billed 4 costs of Comments 1	
The Agency billed 1 unit of Supported (Toold LIB LIB) - 44 (20 (2004))	
Living (T2016 HB-U6) on 11/22/2021.	
Documentation did not contain the	
required elements on 11/22/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
A description of what occurred during	
the encounter or service interval.	
the enecation of dervice interval.	
The Agency hilled 1 unit of Supported	
The Agency billed 1 unit of Supported The Agency billed 1 unit of Supported The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/23/2021.	
Documentation did not contain the	
required elements on 11/23/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
A description of what occurred during	
the encounter or service interval.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/24/2021.	
Documentation did not contain the	
required elements on 11/24/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
A description of what occurred during	
the encounter or service interval.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/25/2021.	
Documentation did not contain the	
Documentation did flot contain the	

required elements on 11/25/2021.	
Documentation received accounted for .5	
units. The required element was not met:	
 A description of what occurred during 	
the encounter or service interval.	
the encounter of service interval.	
 The Agency billed 1 unit of Supported 	
Living (T2016 HB-U6) on 11/26/2021. No	
documentation was found on 11/26/2021	
to justify the 1 unit billed.	
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The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/27/2021. No	
documentation was found on 11/27/2021	
to justify the 1 unit billed.	
 The Agency billed 1 unit of Supported 	
Living (T2016 HB-U6) on 11/28/2021. No	
documentation was found on 11/28/2021	
to justify the 1 unit billed.	
to justify the Funk Smear	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/29/2021.	
Documentation did not contain the	
required elements on 11/29/2021	
Documentation received accounted for .5	
units. The required element was not met:	
A description of what occurred during	
the encounter or service interval.	
and discounter of dorring interval	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U6) on 11/30/2021.	
Documentation did not contain the	
required elements on 11/30/2021	
Documentation received accounted for .5	
units. The required element was not met:	
A description of what occurred during	
the encounter or service interval.	
and discounter of dorring interval	
Individual #12	
September 2021	

The Agency billed 1 unit Living (T2016 HB-U7) or Documentation received units. As indicated by the Standards more than 12 hour period must be probill a complete unit. Documentation received accounted for eless than the required a	n 9/1/2021. d accounted for .5 ne DDW 2 hours in a 24- evided in order to sumentation 4 hours, which is
The Agency billed 1 unit Living (T2016 HB-U7) or Documentation received units. As indicated by the Standards more than 12 hour period must be probill a complete unit. Documentation received accounted for its less than the required.	n 9/2/2021. d accounted for .5 ne DDW 2 hours in a 24- evided in order to sumentation 10 hours, which
The Agency billed 1 unit Living (T2016 HB-U7) or Documentation received units. As indicated by the Standards more than 12 hour period must be probability a complete unit. Documentation received accounted for the less than the required and the standards more than 12 hour period must be probable.	n 9/3/2021. d accounted for .5 ne DDW 2 hours in a 24- evided in order to sumentation 6 hours, which is
The Agency billed 1 unit Living (T2016 HB-U7) or documentation was foun justify the 1 unit billed.	n 9/4/2021. No
The Agency billed 1 unit Living (T2016 HB-U7) of Documentation received units. As indicated by the Standards more than 12 hour period must be probable to the standards.	n 9/5/2021. d accounted for .5 ne DDW 2 hours in a 24- wided in order to

bill a complete unit. Documentation

received accounted for 4 hours, which is	
less than the required amount.	
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 The Agency billed 1 unit of Supported 	
Living (T2016 HB-U7) on 9/8/2021.	
Documentation received accounted for .5	
units. As indicated by the DDW	
Standards more than 12 hours in a 24-	
hour period must be provided in order to	
bill a complete unit. Documentation	
received accounted for 6 hours, which is	
less than the required amount.	
The Agency billed 1 unit of Supported	
Living (T2016 HB-U7) on 9/16/2021. No	
documentation was found on 9/16/2021 to	
justify the 1 unit billed.	
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The Agency billed 1 unit of Supported	
Living (T2016 HB-U7) on 9/17/2021. No	
documentation was found on 9/17/2021 to	
justify the 1 unit billed.	
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 The Agency billed 1 unit of Supported 	
Living (T2016 HB-U7) on 9/18/2021. No	
documentation was found on 9/18/2021 to	
justify the 1 unit billed.	
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The Agency billed 1 unit of Supported	
Living (T2016 HB-U7) on 9/19/2021. No	
documentation was found on 9/19/2021 to	
justify the 1 unit billed.	
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The Agency billed 1 unit of Supported	
Living (T2016 HB-U7) on 9/20/2021. No	
documentation was found on 9/20/2021 to	
justify the 1 unit billed.	
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 The Agency billed 1 unit of Supported 	
Living (T2016 HB-U7) on 9/21/2021.	
Documentation received accounted for .5	
units. As indicated by the DDW	
units. As indicated by the DDW	

Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount.	
The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 9/22/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount.	
 The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 9/23/2021. No documentation was found on 9/23/2021 to justify the 1 unit billed. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 9/24/2021. No documentation was found on 9/24/2021 to justify the 1 unit billed. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 9/25/2021. No documentation was found on 9/25/2021 to justify the 1 unit billed. 	
 The Agency billed 1 unit of Supported Living (T2016 HB-U7 did not contain the required elements on 9/26/2021. Documentation received accounted for .5 units. The required elements was not met: Date, start and end time of each service encounter or other billable service interval. 	

October 2021

- The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 10/1/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount.
- The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 10/19/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount.

November 2021

- The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 11/19/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount.
- The Agency Billed 1 unit of Supported Living (T2016 HB-U7) on 11/26/2021.
 Documentation received accounted for 0 units. Daily note indicated Individual was "out of services."
- The Agency Billed 1 unit of Supported Living (T2016 HB-U7) on 11/27/2021.
 Documentation received accounted for 0 units. Daily note indicated Individual was "out of services."

- The Agency Billed 1 unit of Supported Living (T2016 HB-U7) on 11/28/2021.
 Documentation received accounted for 0 units. Daily note indicated Individual was "out of services."
- The Agency Billed 1 unit of Supported Living (T2016 HB-U7) on 11/29/2021.
 Documentation received accounted for 0 units. Daily note indicated Individual was "out of services."

Individual #15 September 2021

- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 9/8/2021.

 Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 2 hours, which is less than the required amount.
- The Agency Billed 1 unit of Supported Living (T2016 HB-U6) on 9/9/2021.
 Documentation received accounted for 0 units. Daily note indicated Individual was "out of services."
- The Agency Billed 1 unit of Supported Living (T2016 HB-U6) on 9/10/2021.
 Documentation received accounted for 0 units. Daily note indicated Individual was "out of services."
- The Agency Billed 1 unit of Supported Living (T2016 HB-U6) on 9/11/2021.
 Documentation received accounted for 0 units. Daily note indicated Individual was "out of services."

QMB Report of Findings – Advantage Communications System, Inc. – Metro – January 3 - 14, 2022

October 2021

- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/8/2021.
 Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 11 hours, which is less than the required amount.
- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/128/2021.
 Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 5 hours, which is less than the required amount.
- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/17/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount.
- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/19/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount.

- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/21/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 7 hours, which is less than the required amount.
- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 10/22/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8.5 hours, which is less than the required amount.

November 2021

- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/8/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount.
- The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/26/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount.

• The Agency billed 1 unit of Supported Living (T2016 HB-U6) on 11/30/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 9 hours, which is less than the required amount.

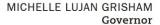
Individual #16 September 2021

- The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 9/1/2021.
 Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 6.75 hours, which is less than the required amount.
- The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 9/29/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount.

November 2021

 The Agency billed 1 unit of Supported Living (T2016 HB-U5) on 11/5/2021.
 Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount.

	Individual #17 September • The Agency billed 1 unit of Supported Living (T2016 HB-U7) on 9/1/2021. Documentation received accounted for .5 units. As indicated by the DDW Standards more than 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount.		
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DAVID R. SCRASE, M.D. Acting Cabinet Secretary

Date: May 18, 2022

To: Joseph Garcia, Executive Director

Provider: Advantage Communication Systems, Inc.

Address: 4219 Montgomery Blvd NE

State/Zip: Albuquerque, New Mexico 87109

E-mail Address: josephgarcia.adv@gmail.com

CC: Laura Veal, Owner

E-mail Address: <u>lsveal@yahoo.com</u>

Region: Metro

Survey Date: January 3 – 14, 2022

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Supported Living, Customized Community Supports, and Community

Integrated Employment Services

Survey Type: Routine

Dear Mr. Garcia:

The Division of Health Improvement Quality Management Bureau received and approved the Plan of Correction you submitted. Your Plan of Correction is not closed.

Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.

The Quality Management Bureau will need to conduct a verification survey to ensure previously cited deficiencies have been corrected and that systemic Quality Improvement and Quality Assurance processes have been effective at sustaining corrections.

If the Verification survey determines survey deficiencies have been corrected and corrective measures have effectively maintained compliance with DDW Standards, your Plan of Correction will be considered for closure.

If the Verification survey identifies repeat deficiencies, the Plan of Correction process will continue and your case may be referred to the Internal Review Committee for discussion of possible civil monetary penalties possible monetary fines and/or other sanctions.

In addition to the Verification survey, the following documents must be submitted no later than <u>May 25, 2022</u> to verify correction of deficiencies:

- Tag 1A25.1
 - Please provide the Caregiver Criminal History Screenings (#516, 526, 543).



- Tag IS25
 - Please provide the Void / Adjust Claims for the billing deficiencies cited in the Tag (#2, 7, 11, 12, 16).
- Tag IS30
 - Please provide the Void / Adjust Claims for the billing deficiencies cited in the Tag (#1, 2, 7, 9, 12, 16, 17).
- Tag LS26
 - Please provide the Void / Adjust Claims for the billing deficiencies cited in the Tag (1, 2, 6, 7, 8, 9, 10, 11, 12, 15, 16, 17).

Thank you for your cooperation with the Plan of Correction process.

Sincerely,

Monica Valdez, BS

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

Q.22.3.DDW.28701224.5.RTN.04.22.138