SUSANA MARTINEZ, GOVERNOR



RETTA WARD, CABINET SECRETARY

Date:	September 23, 2015
To: Provider: Address: State/Zip:	Manish Gaur People Center Services, LLC 1807 2nd Street, Unit 82 Santa Fe, New Mexico, 87505
E-mail Address:	manishgaur@netzero.com
Region: Survey Date: Program Surveyed:	Northeast August 24 – 28, 2015 Developmental Disabilities Waiver
Service Surveyed:	2012: Inclusion Supports (Customized Community Supports, Community Integrated Employment Services) 2007: Community Inclusion (Adult Habilitation)
Survey Type:	Routine
Team Leader:	Nicole Brown, MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Jesus Trujillo, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Stephanie Roybal, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Gaur;

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

Determination of Compliance:

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

Partial Compliance with Conditions of Participation

The following tags are identified as Condition of Participation Level Deficiencies:

- Tag # 1A08.2 Healthcare Requirements
- Tag # 1A15.2 and IS09 /5I09 Healthcare Documentation
- Tag # 1A28.2 Incident Mgt. System Parent/Guardian Training

DIVISION OF HEALTH IMPROVEMENT

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

This determination is based on non-compliance with one or more CMS waiver assurances at the Condition of Participation level as well as Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

Plan of Correction:

The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's 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.

Submission of your Plan of Correction:

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

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

1. Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator 1170 North Solano Suite D Las Cruces, New Mexico 88001

2. Developmental Disabilities Supports Division Regional Office for region of service surveyed

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

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

Billing Deficiencies:

If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a Void/Adjust claims 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: Julie Ann Hill-Clapp HSD/OIG Program Integrity Unit P.O. Box 2348 Santa Fe, New Mexico 87504-2348

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

Attention: Julie Ann Hill-Clapp HSD/OIG Program Integrity Unit 2025 S. Pacheco Street Santa Fe, New Mexico 87505

Please be advised that there is a one-week lag period for applying payments received by check to Voided/Adjusted 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:

QMB Deputy Bureau Chief 5301 Central Ave NE Suite #400 Albuquerque, NM 87108 Attention: IRF request

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

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

Sincerely,

Nicole Brown, MBA

Nicole Brown, MBA Team Lead/Healthcare Surveyor Division of Health Improvement Quality Management Bureau

Survey Process Employed:		
Entrance Conference Date:	August 24, 20)15
Present:	Loretta Lindah	er Services, LLC hl, Manager ez, Direct Support Staff
	Jesus Trujillo,	IB , MBA, Team Lead/Healthcare Surveyor , RN, Healthcare Surveyor yybal, BA, Healthcare Surveyor
Exit Conference Date:	August 28, 20)15
Present:	Manish Gaur,	nen, Service Coordinator
		I <u>B</u> , MBA, Team Lead/Healthcare Surveyor , RN, Healthcare Surveyor
		R <mark>egional Office</mark> eco, Regional Manager, via telephone
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	9
		1 - <i>Jackson</i> Class Members 8 - Non- <i>Jackson</i> Class Members
		 Adult Habilitation Customized Community Supports Community Integrated Employment Services
Persons Served Records Reviewed	Number:	9
Persons Served Interviewed	Number:	6
Persons Served Observed	Number:	3 (Three individuals were unavailable during on-site survey)
Direct Support Personnel Interviewed	Number:	3
Direct Support Personnel Records Reviewed	Number:	6
Service Coordinator Records Reviewed	Number:	2

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
 - o Healthcare Plans
 - o 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
- 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

MFEAD - NM Attorney General

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 Internal Review Committee [IRC] for possible actions or sanctions).

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at <u>AmandaE.Castaneda@state.nm.us</u>. 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 to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, 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 Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

- 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 individuals in similar situations.
- 3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
- 4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and

sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and

- 5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
- 6. The POC must be signed and dated by the agency director or other authorized official.

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

- Details about how and when Consumer, Personnel and Residential 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, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc.;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans are reviewed to verify they meet requirements, how the timeliness of 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: <u>Instruction or in-service of staff alone may not be a sufficient plan of correction.</u> This is a good first step toward correction, but additional steps must be taken to ensure the deficiency is corrected and will not recur.

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

- 1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
- 2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at <u>AmandaE.Castaneda@state.nm.us</u> for assistance.
- 3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
- 4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
 - a. Electronically at <u>AmandaE.Castaneda@state.nm.us</u> (preferred method)
 - b. Fax to 575-528-5019, or
 - c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001
- 5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
- 6. QMB will notify you when your POC has been "approved" or "denied."

- a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
- b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
- c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
- d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
- e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
- 7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

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

- 1. Your internal documents are due within a *maximum* of 45 business days of receipt of your Report of Findings.
- 2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you 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.
- 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. In addition to this, we ask that you submit:
 - Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
 - Copies of "void and adjust" forms submitted to Xerox State Healthcare, LLC to correct all unjustified units identified and submitted for payment during your internal audit.

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

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 state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; 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 Management 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 in the QMB Report of Findings. 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.

Within the QMB Service Domains there are fundamental regulations, standards, or policies with which a provider must be in essential compliance in order to ensure the health and welfare of individuals served known as Conditions of Participation (CoPs).

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in three (3) Service Domains.

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

- Qualified Provider
- Plan of Care
- Health, Welfare and Safety

Conditions of Participation (CoPs)

A CoP is an identified fundamental regulation, standard, or policy with which a provider must be in compliance in order to ensure the health and welfare of individuals served. CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances. A provider must be in compliance with CoPs to participate as a waiver provider.

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP (See the next section for a list of CoPs). The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of a CoP out of compliance, it is cited as a Standard Level Deficiency.

The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

CoPs and Service Domains for Case Management Supports are as follows:

Service Domain: Level of Care

Condition of Participation:

1. Level of Care: The Case Manager shall complete all required elements of the Long Term Care Assessment Abstract (LTCAA) to ensure ongoing eligibility for waiver services.

Service Domain: Plan of Care

Condition of Participation:

2. Individual Service Plan (ISP) Creation and Development: Each individual shall have an ISP. The ISP shall be developed in accordance with DDSD regulations and standards and is updated at least annually or when warranted by changes in the individual's needs.

Condition of Participation:

3. **ISP Monitoring and Evaluation:** The Case Manager shall ensure the health and welfare of the individual through monitoring the implementation of ISP desired outcomes.

CoPs and Service Domain for ALL Service Providers is as follows:

Service Domain: Qualified Providers

- Condition of Participation:
- 4. **Qualified Providers**: Agencies shall ensure support staff has completed criminal background screening and all mandated trainings as required by the DDSD.

CoPs and Service Domains for Living Supports and Inclusion Supports are as follows:

Service Domain: Plan of Care

Condition of Participation:

5. **ISP Implementation**: Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

Service Domain: Health, Welfare and Safety

Condition of Participation:

6. Individual Health, Safety and Welfare: (Safety) Individuals have the right to live and work in a safe environment.

Condition of Participation:

7. Individual Health, Safety and Welfare (Healthcare Oversight): The provider shall support individuals to access needed healthcare services in a timely manner. Nursing, healthcare services and healthcare oversight shall be available and provided as needed to address individuals' health, safety and welfare.

QMB Determinations of Compliance

Compliance with Conditions of Participation

The QMB determination of *Compliance with Conditions of Participation* indicates that a provider is in compliance with all Conditions of Participation, (CoP). 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 with Conditions of Participation, the provider must be in compliance with all Conditions of Participation in all relevant Service Domains. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) out of compliance in any of the Service Domains.

Partial-Compliance with Conditions of Participation

The QMB determination of *Partial-Compliance with Conditions of Participation* indicates that a provider is out of compliance with Conditions of Participation in one (1) to two (2) Service Domains. The agency may have one or more Condition level tags within a Service Domain. 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. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains.

Providers receiving a <u>repeat</u> determination of Partial-Compliance for repeat deficiencies at the level of a Condition in any Service Domain may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

Non-Compliance with Conditions of Participation

The QMB determination of *Non-Compliance with Conditions of Participation* indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains. 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. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

Providers receiving a <u>repeat</u> determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

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

Introduction:

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

Instructions:

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

Agency:	People Center Services, LLC – Northeast Region
Program:	Developmental Disabilities Waiver
Service:	2012: Inclusion Supports (Customized Community Supports, Community Integrated Employment Services)
	2007: Community Inclusion (Adult Habilitation)
Monitoring Type:	Routine Survey
Survey Date:	August 24 – 28, 2015

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
		n accordance with the service plan, inclu	ding
type, scope, amount, duration and freq			
Tag # 1A08 Agency Case File	Standard Level Deficiency		
 Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 Chapter 5 (CIES) 3. Agency Requirements H. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy. Additional documentation that is required to be maintained at the administrative office includes: 1. Vocational Assessments that are of quality and contain content acceptable to DVR and DDSD; 2. Career Development Plans as incorporated in the ISP; and 3. Documentation of evidence that services provided under the DDW are not otherwise available under the Rehabilitation Act of 1973 (DVR). Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office 	 Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 8 of 9 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: ISP budget forms MAD 046 Not Found (#2, 8, 9) (No POC required as budget is delayed due to Third Party Assessor #2, 8, 9) Current Emergency and Personal Identification Information None Found (#2) Did not contain names and phone numbers of relatives, or guardian or conservator. (#8) 	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. Additional documentation that is required to be maintained at the administrative office includes:	ISP Signature Page (#9)Positive Behavioral Support Plan (#7)		

1 Vacational Accompany (if applicable) that		
 Vocational Assessments (if applicable) that are of quality and contain content acceptable 	• Speech Therapy Plan (#5, 8, 9)	
to DVR and DDSD.		
	Occupational Therapy Plan (#7)	
Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.	Documentation of Guardianship/Power of Attorney (#1, 3, 4, 5)	
Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.		
Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.		
 Chapter 13 (IMLS) 2. Service Requirements: C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items) Emergency contact information; Personal identification; ISP budget forms and budget prior authorization; ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan (PBSP), Behavior Crisis Intervention Plan (BCIP), or other relevant behavioral plans, Medical Emergency Response Plan (MERP), 		

Healthcare Plan, Comprehensive Aspiration Risk	
Management Plan (CARMP), and Written Direct	
Support Instructions (WDSI);	
 Dated and signed evidence that the individual 	
has been informed of agency	
grievance/complaint procedure at least annually,	
or upon admission for a short term stay;	
Copy of Guardianship or Power of Attorney	
documents as applicable;	
Behavior Support Consultant, Occupational	
Therapist, Physical Therapist and Speech-	
Language Pathology progress reports as	
applicable, except for short term stays;	
 Written consent by relevant health decision 	
maker and primary care practitioner for self-	
administration of medication or assistance with	
medication from DSP as applicable;	
 Progress notes written by DSP and nurses; 	
Signed secondary freedom of choice form;	
Transition Plan as applicable for change of	
provider in past twelve (12) months.	
DEVELOPMENTAL DISABILITIES SUPPORTS	
DIVISION (DDSD): Director's Release: Consumer	
Record Requirements eff. 11/1/2012	
III. Requirement Amendments(s) or	
Clarifications:	
A. All case management, living supports, customized	
in-home supports, community integrated	
employment and customized community supports	
providers must maintain records for individuals	
served through DD Waiver in accordance with the	
Individual Case File Matrix incorporated in this	
director's release.	
H. Readily accessible electronic records are	
accessible, including those stored through the	
Therap web-based system.	
Developmental Disabilities (DD) Waiver Service	
Standards effective 4/1/2007	
CHAPTER 1 II. PROVIDER AGENCY	
REQUIREMENTS: D. Provider Agency Case	

File for the Individual: All Provider Agencies shall		
maintain at the administrative office a confidential		
case file for each individual. Case records belong		
to the individual receiving services and copies shall		
be provided to the receiving agency whenever an		
individual changes providers. The record must		
also be made available for review when requested		
by DOH, HSD or federal government		
representatives for oversight purposes. The		
individual's case file shall include the following		
requirements:		
(1) Emergency contact information, including the		
individual's address, telephone number, names		
and telephone numbers of relatives, or guardian		
or conservator, physician's name(s) and		
telephone number(s), pharmacy name, address		
and telephone number, and health plan if		
appropriate;		
(2) The individual's complete and current ISP, with		
all supplemental plans specific to the individual,		
and the most current completed Health		
Assessment Tool (HAT);		
(3) Progress notes and other service delivery		
documentation;		
(4) Crisis Prevention/Intervention Plans, if there		
are any for the individual;		
(5) A medical history, which shall include at least		
demographic data, current and past medical		
diagnoses including the cause (if known) of the		
developmental disability, psychiatric diagnoses,		
allergies (food, environmental, medications),		
immunizations, and most recent physical exam;		
(6) When applicable, transition plans completed for individuals at the time of discharge from Fort		
Stanton Hospital or Los Lunas Hospital and		
Training School; and		
(7) Case records belong to the individual receiving		
services and copies shall be provided to the		
individual upon request.		
(8) The receiving Provider Agency shall be		
provided at a minimum the following records		
whenever an individual changes provider		
agencies:		
uyunuus.		

(a) Complete file for the past 12 months;		
(b) ISP and quarterly reports from the current		
and prior ISP year;		
(c) Intake information from original admission		
to services; and		
(d) When applicable, the Individual Transition		
Plan at the time of discharge from Los		
Lunas Hospital and Training School or Ft.		
Stanton Hospital.		
NMAC 8.302.1.17 RECORD KEEPING AND		
DOCUMENTATION REQUIREMENTS: A provider		
must maintain all the records necessary to fully		
disclose the nature, quality, amount and medical		
necessity of services furnished to an eligible		
recipient who is currently receiving or who has		
received services in the past.		
B. Documentation of test results: Results of		
tests and services must be documented, which		
includes results of laboratory and radiology		
procedures or progress following therapy or		
treatment.		

Tag # 1A08.1	Standard Level Deficiency		
Agency Case File - Progress Notes		Deadles	
Developmental Disabilities (DD) Waiver Service	Based on record review, the Agency did not	Provider:	
Standards effective 11/1/2012 revised 4/23/2013	maintain progress notes and other service	State your Plan of Correction for the	
Chapter 5 (CIES) 3. Agency Requirements: 6. Reimbursement A. 1 Provider Agencies	delivery documentation for 1 of 9 Individuals.	deficiencies cited in this tag here: \rightarrow	
must maintain all records necessary to fully	Review of the Agency individual case files		
disclose the service, qualityThe	revealed the following items were not found:		
documentation of the billable time spent with an			
individual shall be kept on the written or electronic record	Customized Community Services Notes/Daily Contact Logs		
Chapter 6 (CCS) 3. Agency Requirements: 4.	 Individual #8 - None found for 07/08/2015 – 		
Reimbursement A. Record Requirements 1.	07/14/2015		
Provider Agencies must maintain all records			
necessary to fully disclose the service,			
qualityThe documentation of the billable time			
spent with an individual shall be kept on the		Provider:	
written or electronic record		Enter your ongoing Quality Assurance/Quality	
		Improvement processes as it related to this tag	
Chapter 7 (CIHS) 3. Agency Requirements: 4.		number here: \rightarrow	
Reimbursement A. 1Provider Agencies must			
maintain all records necessary to fully disclose			
the service, qualityThe documentation of the			
billable time spent with an individual shall be			
kept on the written or electronic record			
Chapter 11 (FL) 3. Agency Requirements: 4.			
Reimbursement A. 1Provider Agencies must			
maintain all records necessary to fully disclose			
the service, qualityThe documentation of the billable time spent with an individual shall be			
kept on the written or electronic record			
Rept on the written of electronic record			
Chapter 12 (SL) 3. Agency Requirements:			
2. Reimbursement A. 1. Provider Agencies			
must maintain all records necessary to fully			
disclose the service, qualityThe			
documentation of the billable time spent with an			
individual shall be kept on the written or			
electronic record			

Chapter 13 (IMLS) 3. Agency Requirements: 4. Reimbursement A. 1Provider Agencies must maintain all records necessary to fully disclose the service, qualityThe documentation of the billable time spent with an individual shall be kept on the written or electronic record		
Chapter 15 (ANS) 4. Reimbursement A. 1. Provider Agencies must maintain all records necessary to fully disclose the service, qualityThe documentation of the billable time spent with an individual shall be kept on the written or electronic record		
 Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (3) Progress notes and other service delivery documentation; 		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
		QA/QI and Responsible Party fied providers to assure adherence to waiv ovider training is conducted in accordance Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag	er
 safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency) NMAC 7.9.2 F. TRANSPORTATION: (1) Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training 	• DSP 204 stated "No, but I have with R-Way."	number here: →	

program in passenger transportation assistance		
before assisting any resident. The passenger		
transportation assistance program shall be		
comprised of but not limited to the following		
elements: resident assessment, emergency		
procedures, supervised practice in the safe		
operation of equipment, familiarity with state		
regulations governing the transportation of persons		
with disabilities, and a method for determining and		
documenting successful completion of the		
course. The course requirements above are		
examples and may be modified as needed.		
(2) Any employee or agent of a regulated facility		
or agency who drives a motor vehicle provided by		
the facility or agency for use in the transportation of		
clients must complete:		
(a) A state approved training program in		
passenger assistance and		
(b) A state approved training program in the		
operation of a motor vehicle to transport clients of		
a regulated facility or agency. The motor vehicle		
transportation assistance program shall be		
comprised of but not limited to the following		
elements: resident assessment, emergency		
procedures, supervised practice in the safe		
operation of motor vehicles, familiarity with state		
regulations governing the transportation of persons		
with disabilities, maintenance and safety record		
keeping, training on hazardous driving conditions		
and a method for determining and documenting		
successful completion of the course. The course		
requirements above are examples and may be		
modified as needed.		
(c) A valid New Mexico driver's license for the		
type of vehicle being operated consistent with		
State of New Mexico requirements.		
(3) Each regulated facility and agency shall		
establish and enforce written polices (including		
training) and procedures for employees who		
provide assistance to clients with boarding or		
alighting from motor vehicles.		
(4) Each regulated facility and agency shall		
establish and enforce written polices (including		

training and procedures for employees who operate motor vehicles to transport clients.	
operate motor venicies to transport clients.	
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013	
CHAPTER 5 (CIES) 3. Agency Requirements G.	
Training Requirements: 1. All Community	
Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training	
Requirements for Direct Service Agency Staff	
Policy.	
CHAPTER 6 (CCS) 3. Agency Requirements F.	
Meet all training requirements as follows: 1. All	
Customized Community Supports Providers shall provide staff training in accordance with the DDSD	
Policy T-003: Training Requirements for Direct	
Service Agency Staff Policy;	
CHAPTER 7 (CIHS) 3. Agency Requirements C.	
Training Requirements: The Provider Agency must report required personnel training status to	
the DDSD Statewide Training Database as	
specified in the DDSD Policy T-001: Reporting	
and Documentation of DDSD Training Requirements Policy. The Provider Agency must	
ensure that the personnel support staff have	
completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service	
Agency Staff Policy	
CHAPTER 11 (FL) 3. Agency Requirements B.	
Living Supports- Family Living Services	
Provider Agency Staffing Requirements: 3.	
Training: A. All Family Living Provider agencies must	
ensure staff training in accordance with the	
Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering	
substitute care under Family Living must at a	
minimum comply with the section of the training	
policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training	

Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.		
 CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training: A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP 		
Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;		

Direct Support Personnel Training Based on record review, the Agency did not Disabilites Supports Division (DDSD) Policy-Policy Title: Training Requirements for Direct Support Personnel. Provider: Direct Support Division (DDSD) Policy - Eff. March 1, 2007 II. POLICY STATEMENTS: Review of Direct Support Personnel training requirements were met for 3 of 6 Direct Support Personnel. State your Plan of Correction for the deficiencies cited in this tag here: → A. Individuals shall receive services from competent and qualified staff. Review of Direct Support Personnel training requirements were met for 3 of 6 Direct Support Personnel. State your Plan of Correction for the deficiencies cited in this tag here: → State shall complete individual service plan (ISP) of each individual served. Foundation for Health and Wellness (DSP #205) Furst Aid (DSP #210, 203) O. Staff shall complete training metarias shall meet OSHA requirements. First Aid (DSP #210, 203) Provider: Direct Support Personal Safety and Health Administration (OSHA) requirements. C. Staff shall complete relevant training metariang materials shall meet OSHA requirements. C. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Madt, CPI) before using physical restraint techniques. Shall mether intervention system (e.g., Madt, CPI) before using physical restraint techniques shall meanting metariant tervention in a DDSD-approved behavioral intervention system (e.g., Madt, CPI) before using physical restraint techniques shall meanting materiang there shavioral environments. Frevider: E. Staff whor	Tag # 1A20	Standard Level Deficiency		
 Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerty known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 77 D. Staff shall complete training and complete training in universal precautions on an annual basis. The training materials shall meet OCCupational Safety and Health Administration (OSHA) requirements. F. Staff who may be exposed to hazardous chemicals shall meer OSHA requirements. F. Staff who may be exposed to hazardous chemicals shall meer with OSD-approved behavioral intervention in a DDSD-approved behavioral intervention in a DDSD-approved behavioral 				
Intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery	 Direct Support Personnel Training Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines. F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in 	 Based on record review, the Agency did not ensure Orientation and Training requirements were met for 3 of 6 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: Foundation for Health and Wellness (DSP #205) First Aid (DSP #210, 203) 	State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag	

employment and before working alone with an individual receiving service.	
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy.	
CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;	
CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy	
CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training: A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and	

Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.		
CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training: A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.		
CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;		

Tag # 1A22	Standard Level Deficiency		
Agency Personnel Competency			
Department of Health (DOH) Developmental	Based on interview, the Agency did not ensure	Provider:	
Disabilities Supports Division (DDSD) Policy	training competencies were met for 2 of 3 Direct	State your Plan of Correction for the	
- Policy Title: Training Requirements for	Support Personnel.	deficiencies cited in this tag here: \rightarrow	
Direct Service Agency Staff Policy - Eff.			
March 1, 2007 - II. POLICY STATEMENTS:	When DSP were asked if they received		
A. Individuals shall receive services from	training on the Individual's Individual Service		
competent and qualified staff.	Plan and what the plan covered, the		
B. Staff shall complete individual specific	following was reported:		
(formerly known as "Addendum B") training			
requirements in accordance with the	DSP #204 stated, "Not through People		
specifications described in the individual service	Centered Services, through another agency."		
plan (ISP) for each individual serviced.	(Individual #3)		
Developmental Disabilities (DD) Waiver Service	When DSP were asked if the Individual had a		
Standards effective 11/1/2012 revised 4/23/2013	Positive Behavioral Supports Plan and if so,	Provider:	
CHAPTER 5 (CIES) 3. Agency Requirements	what the plan covered, the following was	Enter your ongoing Quality Assurance/Quality	
G. Training Requirements: 1. All Community	reported:	Improvement processes as it related to this tag	
Inclusion Providers must provide staff training in		number here: \rightarrow	
accordance with the DDSD policy T-003:	 DSP #204 stated, "Yes, I don't know his 		
Training Requirements for Direct Service	therapist would." DSP #204 could not		
Agency Staff Policy. 3. Ensure direct service	describe what the plan states, yet according		
personnel receives Individual Specific Training	to the Individual Specific Training Section of		
as outlined in each individual ISP, including	the ISP the Individual requires a Positive		
aspects of support plans (healthcare and	Behavioral Supports Plan and DSP are to be		
behavioral) or WDSI that pertain to the	trained by the Behavior Therapist. (Individual		
employment environment.	#3)		
CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:	When DSP were asked if the Individual had a		
1. All Customized Community Supports	Medical Emergency Response Plans and if		
Providers shall provide staff training in	so, what the plan(s) covered, the following		
accordance with the DDSD Policy T-003:	was reported:		
Training Requirements for Direct Service	DOD #202 stated "No." As indicated but the		
Agency Staff Policy;	 DSP #202 stated, "No." As indicated by the Individual Specific Training continue of the ISP 		
	Individual Specific Training section of the ISP indicates the Individual requires Medical		
CHAPTER 7 (CIHS) 3. Agency Requirements	Emergency Response Plan for Seizures.		
C. Training Requirements: The Provider	(Individual #2)		
Agency must report required personnel training			
3,			

status to the DDSD Statewide Training	
Database as specified in the DDSD Policy T-	
001: Reporting and Documentation of DDSD	
Training Requirements Policy. The Provider	
Agency must ensure that the personnel support	
staff have completed training as specified in the	
DDSD Policy T-003: Training Requirements for	
Direct Service Agency Staff Policy. 3. Staff shall	
complete individual specific training	
requirements in accordance with the	
specifications described in the ISP of each	
individual served; and 4. Staff that assists the	
individual with medication (e.g., setting up	
medication, or reminders) must have completed	
Assisting with Medication Delivery (AWMD)	
Training.	
CHAPTER 11 (FL) 3. Agency Requirements	
B. Living Supports- Family Living Services	
Provider Agency Staffing Requirements: 3.	
Training:	
A. All Family Living Provider agencies must	
ensure staff training in accordance with the	
Training Requirements for Direct Service	
Agency Staff policy. DSP's or subcontractors	
delivering substitute care under Family Living	
must at a minimum comply with the section of	
the training policy that relates to Respite,	
Substitute Care, and personal support staff	
[Policy T-003: for Training Requirements for	
Direct Service Agency Staff; Sec. II-J, Items 1-	
4]. Pursuant to the Centers for Medicare and	
Medicaid Services (CMS) requirements, the	
services that a provider renders may only be	
claimed for federal match if the provider has	
completed all necessary training required by the	
state. All Family Living Provider agencies must	
report required personnel training status to the	
DDSD Statewide Training Database as specified	
in DDSD Policy T-001: Reporting and	

Documentation for DDSD Training	
Requirements.	
B. Individual specific training must be arranged	
and conducted, including training on the	
Individual Service Plan outcomes, actions steps	
and strategies and associated support plans	
(e.g. health care plans, MERP, PBSP and BCIP	
etc.), information about the individual's	
preferences with regard to privacy,	
communication style, and routines. Individual	
specific training for therapy related WDSI,	
Healthcare Plans, MERPs, CARMP, PBSP, and	
BCIP must occur at least annually and more	
often if plans change or if monitoring finds	
incorrect implementation. Family Living	
providers must notify the relevant support plan	
author whenever a new DSP is assigned to work	
with an individual, and therefore needs to	
receive training, or when an existing DSP	
requires a refresher. The individual should be	
present for and involved in individual specific	
training whenever possible.	
CHAPTER 12 (SL) 3. Agency Requirements	
B. Living Supports- Supported Living	
Services Provider Agency Staffing	
Requirements: 3. Training:	
A. All Living Supports- Supported Living	
Provider Agencies must ensure staff training in	
accordance with the DDSD Policy T-003: for	
Training Requirements for Direct Service	
Agency Staff. Pursuant to CMS requirements,	
the services that a provider renders may only be	
claimed for federal match if the provider has	
completed all necessary training required by the	
state. All Supported Living provider agencies	
must report required personnel training status to	
the DDSD Statewide Training Database as	
specified in DDSD Policy T-001: Reporting and	
Documentation for DDSD Training	
Requirements.	

B Individual specific training must be arranged		
and conducted, including training on the ISP		
Outcomes, actions steps and strategies,		
associated support plans (e.g. health care plans,		
MERP, PBSP and BCIP, etc.), and information		
about the individual's preferences with regard to		
privacy, communication style, and routines.		
Individual specific training for therapy related		
WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually		
and more often if plans change or if monitoring		
finds incorrect implementation. Supported		
Living providers must notify the relevant support		
plan author whenever a new DSP is assigned to		
work with an individual, and therefore needs to		
receive training, or when an existing DSP		
requires a refresher. The individual should be		
present for and involved in individual specific		
training whenever possible.		
CHAPTER 13 (IMLS) R. 2. Service		
Requirements. Staff Qualifications 2. DSP		
Qualifications. E. Complete training		
requirements as specified in the DDSD Policy T-		
003: Training Requirements for Direct Service		
Agency Staff - effective March 1, 2007. Report		
required personnel training status to the DDSD		
Statewide Training Database as specified in the		
DDSD Policy T-001: Reporting and		
Documentation of DDSD Training Requirements		
Policy;		

Tag # 1A25	Standard Level Deficiency		
Criminal Caregiver History Screening			
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT	Based on record review, the Agency did not maintain documentation indicating no	Provider: State your Plan of Correction for the	
REQUIREMENTS:	"disqualifying convictions" or documentation of	deficiencies cited in this tag here: \rightarrow	
F. Timely Submission: Care providers shall	the timely submission of pertinent application		
submit all fees and pertinent application	information to the Caregiver Criminal History		
information for all individuals who meet the	Screening Program was on file for 1 of 6 Agency		
definition of an applicant, caregiver or hospital	Personnel.		
caregiver as described in Subsections B, D and			
K of 7.1.9.7 NMAC, no later than twenty (20)	The following Agency Personnel Files		
calendar days from the first day of employment	contained no evidence of Caregiver Criminal		
or effective date of a contractual relationship	History Screenings:		
with the care provider.			
	Direct Support Personnel (DSP):		
NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL		Drevider	
CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:	• #203– Date of hire 10/14/2014.	Provider: Enter your ongoing Quality Assurance/Quality	
A. Prohibition on Employment: A care		Improvement processes as it related to this tag	
provider shall not hire or continue the		number here: \rightarrow	
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.			
(1) In cases where the criminal history record			
lists an arrest for a crime that would constitute a			
disqualifying conviction and no final disposition			
is listed for the arrest, the department will			
attempt to notify the applicant, caregiver or			
hospital caregiver and request information from			
the applicant, caregiver or hospital caregiver within timelines set forth in the department's			
notice regarding the final disposition of the			
arrest. Information requested by the department			
may be evidence, for example, a certified copy			
of an acquittal, dismissal or conviction of a			
lesser included crime.			
(2) An applicant's, caregiver's or hospital			
caregiver's failure to respond within the required			

timelines regarding the final disposition of the		
arrest for a crime that would constitute a		
disqualifying conviction shall result in the		
applicant's, caregiver's or hospital caregiver's		
temporary disqualification from employment as a		
caregiver or hospital caregiver pending written		
documentation submitted to the department		
evidencing the final disposition of the arrest.		
Information submitted to the department may be		
evidence, for example, of the certified copy of an		
acquittal, dismissal or conviction of a lesser		
included crime. In instances where the applicant,		
caregiver or hospital caregiver has failed to		
respond within the required timelines the		
department shall provide notice by certified mail		
that an employment clearance has not been		
granted. The Care Provider shall then follow the		
procedure of Subsection A., of Section 7.1.9.9.		
(3) The department will not make a final		
determination for an applicant, caregiver or		
hospital caregiver with a pending potentially		
disqualifying conviction for which no final		
disposition has been made. In instances of a		
pending potentially disqualifying conviction for		
which no final disposition has been made, the		
department shall notify the care provider,		
applicant, caregiver or hospital caregiver by		
certified mail that an employment clearance has		
not been granted. The Care Provider shall then		
follow the procedure of Subsection A, of Section		
7.1.9.9.		
B. Employment Pending Reconsideration		
Determination: At the discretion of the care		
provider, an applicant, caregiver or hospital		
caregiver whose nationwide criminal history		
record reflects a disqualifying conviction and		
who has requested administrative		
reconsideration may continue conditional		
supervised employment pending a determination		
on reconsideration.		

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 # 1A26	Standard Level Deficiency		
Consolidated On-line Registry			
Employee Abuse Registry			
NMAC 7.1.12.8 REGISTRY ESTABLISHED;	Based on record review, the Agency did not	Provider:	
PROVIDER INQUIRY REQUIRED: Upon the	maintain documentation in the employee's	State your Plan of Correction for the	
effective date of this rule, the department has		deficiencies cited in this tag here: \rightarrow	
established and maintains an accurate and	Employee Abuse Registry prior to employment		
complete electronic registry that contains the	for 2 of 8 Agency Personnel.		
name, date of birth, address, social security			
number, and other appropriate identifying	The following Agency personnel records		
information of all persons who, while employed	contained no evidence of the Employee		
by a provider, have been determined by the	Abuse Registry check being completed:		
department, as a result of an investigation of a			
complaint, to have engaged in a substantiated	Direct Support Personnel (DSP):		
registry-referred incident of abuse, neglect or			
exploitation of a person receiving care or	 #203 – Date of hire 10/14/2014. 		
services from a provider. Additions and updates		Description	
to the registry shall be posted no later than two	The following Agency Personnel records	Provider:	
(2) business days following receipt. Only	contained evidence that indicated the	Enter your ongoing Quality Assurance/Quality	
department staff designated by the custodian may access, maintain and update the data in the	Employee Abuse Registry check was	Improvement processes as it related to this tag number here: \rightarrow	
registry.	completed after hire:		
A. Provider requirement to inquire of	Direct Support Personnel (DSP):		
registry. A provider, prior to employing or	Direct Support Personner (DSP).		
contracting with an employee, shall inquire of	 #200 – Date of hire 8/6/2014, completed 		
the registry whether the individual under	 #200 – Date of file 8/6/2014, completed 8/26/2014. 		
consideration for employment or contracting is	8/20/2014:		
listed on the registry.			
B. Prohibited employment. A provider			
may not employ or contract with an individual to			
be an employee if the individual is listed on the	-		
registry as having a substantiated registry-			
referred incident of abuse, neglect or			
exploitation of a person receiving care or			
services from a provider.			
D. Documentation of inquiry to registry.			
The provider shall maintain documentation in the			
employee's personnel or employment records			
that evidences the fact that the provider made			
an inquiry to the registry concerning that			

employee prior to employment. Such		
documentation must include evidence, based on		
the response to such inquiry received from the		
custodian by the provider, that the employee		
was not listed on the registry as having a		
substantiated registry-referred incident of abuse,		
neglect or exploitation.		
E. Documentation for other staff. With		
respect to all employed or contracted individuals		
providing direct care who are licensed health		
care professionals or certified nurse aides, the		
provider shall maintain documentation reflecting		
the individual's current licensure as a health		
care professional or current certification as a		
nurse aide.		
F. Consequences of noncompliance.		
The department or other governmental agency having regulatory enforcement authority over a		
provider may sanction a provider in accordance		
with applicable law if the provider fails to make		
an appropriate and timely inquiry of the registry,		
or fails to maintain evidence of such inquiry, in		
connection with the hiring or contracting of an		
employee; or for employing or contracting any		
person to work as an employee who is listed on		
the registry. Such sanctions may include a		
directed plan of correction, civil monetary		
penalty not to exceed five thousand dollars		
(\$5000) per instance, or termination or non-		
renewal of any contract with the department or		
other governmental agency.		

Tag # 1A28.1	Standard Level Deficiency		
Incident Mgt. System - Personnel			
Training			
NMAC 7.1.14 ABUSE, NEGLECT,	Based on record review and interview, the	Provider:	
EXPLOITATION, AND DEATH REPORTING,	Agency did not ensure Incident Management	State your Plan of Correction for the	1.1
TRAINING AND RELATED REQUIREMENTS	Training for 4 of 8 Agency Personnel.	deficiencies cited in this tag here: \rightarrow	
FOR COMMUNITY PROVIDERS		Ŭ	
	Direct Support Personnel (DSP):		
NMAC 7.1.14.9 INCIDENT MANAGEMENT	 Incident Management Training (Abuse, 		
SYSTEM REQUIREMENTS:	Neglect and Exploitation) (DSP# 201, 202,		
A. General: All community-based service	203, 204)		
providers shall establish and maintain an incident			
management system, which emphasizes the			
principles of prevention and staff involvement.			
The community-based service provider shall			
ensure that the incident management system			
policies and procedures requires all employees			
and volunteers to be competently trained to		Provider:	
respond to, report, and preserve evidence related		Enter your ongoing Quality Assurance/Quality	
to incidents in a timely and accurate manner.		Improvement processes as it related to this tag	
B. Training curriculum: Prior to an employee or		number here: \rightarrow	
volunteer's initial work with the community-based			
service provider, all employees and volunteers			
shall be trained on an applicable written training			
curriculum including incident policies and			
procedures for identification, and timely reporting			
of abuse, neglect, exploitation, suspicious injury,			
and all deaths as required in Subsection A of			
7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The			
training curriculum as set forth in Subsection C of			
7.1.14.9 NMAC may include computer-based			
training. Periodic reviews shall include, at a			
minimum, review of the written training curriculum			
and site-specific issues pertaining to the			
community-based service provider's facility.			
Training shall be conducted in a language that is			
understood by the employee or volunteer.			
C. Incident management system training			
curriculum requirements:			

(1) The community-based service provider		
shall conduct training or designate a		
knowledgeable representative to conduct		
training, in accordance with the written training		
curriculum provided electronically by the		
division that includes but is not limited to:		
(a) an overview of the potential risk of		
abuse, neglect, or exploitation;		
(b) informational procedures for properly		
filing the division's abuse, neglect, and		
exploitation or report of death form;		
(c) specific instructions of the employees'		
legal responsibility to report an incident of		
abuse, neglect and exploitation, suspicious		
injury, and all deaths;		
(d) specific instructions on how to respond to		
abuse, neglect, or exploitation;		
(e) emergency action procedures to be		
followed in the event of an alleged incident or		
knowledge of abuse, neglect, exploitation, or		
suspicious injury.		
(2) All current employees and volunteers		
shall receive training within 90 days of the		
effective date of this rule.		
(3) All new employees and volunteers shall		
receive training prior to providing services to		
consumers.		
D. Training documentation: All community-		
based service providers shall prepare training		
documentation for each employee and volunteer		
to include a signed statement indicating the date,		
time, and place they received their incident		
management reporting instruction. The		
community-based service provider shall maintain		
documentation of an employee or volunteer's		
training for a period of at least three years, or six		
months after termination of an employee's		
employment or the volunteer's work. Training		
curricula shall be kept on the provider premises		
and made available upon request by the		
department. Training documentation shall be		

 made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule. Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH- approved incident reporting procedures in accordance with 7 NMAC 1.13. 		

_	Standard Level Deficiency		
Service Coordination Requirements			
	Based on record review, the Agency did not	Provider:	
	ensure that Orientation and Training	State your Plan of Correction for the	
		deficiencies cited in this tag here: \rightarrow	
······································	Coordinators.		
March 1, 2007 - II. POLICY STATEMENTS:			
	Review of Service Coordinators training records		
	found no evidence of the following required		
	DOH/DDSD trainings being completed:		
supervisors, and internal service coordinators			
shall complete DDSD-approved core	 Sexuality for People with Developmental 		
curriculum training. Attachments A and B to	Disabilities (SC #206)		
this policy identify the specific competency			
requirements for the following levels of core			
curriculum training:			
1. Introductory Level – must be completed within		Provider:	
thirty (30) days of assignment to his/her		Enter your ongoing Quality Assurance/Quality	
position with the agency.		Improvement processes as it related to this tag	
2. Orientation – must be completed within ninety		number here: \rightarrow	
(90) days of assignment to his/her position			
with the agency.			
3. Level I – must be completed within one (1)			
year of assignment to his/her position with the			
agency.			
NMAC 7.26.5.7 "service coordinator": the			
community provider staff member, sometimes			
called the program manager or the internal			
case manager, who supervises, implements			
and monitors the service plan within the			
community service provider agency			
NMAC 7.26.5.11 (b) service coordinator: the			
service coordinators of the community provider			
agencies shall assure that appropriate staff			
develop strategies specific to their			
responsibilities in the ISP; the service			
coordinators shall assure the action plans and			
strategies are implemented consistent with the			

provisions of the ISP, and shall report to the		
case manager on ISP implementation and the		
individual's progress on action plans within their		
agencies; for persons funded solely by state		
general funds, the service coordinator shall		
assume all the duties of the independent case		
manager described within these regulations; if		
there are two or more "key" community service		
provider agencies with two or more service		
coordinator staff, the IDT shall designate which		
service coordinator shall assume the duties of		
the case manager; the criteria to guide the IDTs		
selection are set forth as follows:		
(i) the designated service coordinator shall		
have the skills necessary to carry out the		
duties and responsibilities of the case		
manager as defined in these regulations;		
(ii) the designated service coordinator shall		
have the time and interest to fulfill the		
functions of the case manager as defined in		
these regulations;		
(iii) the designated service coordinator shall be		
familiar with and understand community		
service delivery and supports;		
(iv) the designated service coordinator shall		
know the individual or be willing to become		
familiar and develop a relationship with the		
individual being served;		
individual boing borvou,		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
abuse, neglect and exploitation. Individua needed healthcare services in a timely ma	als shall be afforded their basic human righ anner.	addresses and seeks to prevent occurrence ts. The provider supports individuals to ac	
Tag #1A08.2 Healthcare Requirements	Condition of Participation Level Deficiency		
 NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. 	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 provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 9 of 9 individuals receiving Community Inclusion and Living Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
 DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications: A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. 	 Community Inclusion Services / Other Services Healthcare Requirements (Individuals Receiving Inclusion / Other Services Only): Annual Physical (#1, 2, 3, 4, 7, 8, 9) Dental Exam Individual #2 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. Individual #3 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. 	Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Developmental Disabilities (DD) Waiver Service	 Individual #4 - As indicated by the DDSD file 	
Standards effective 11/1/2012 revised 4/23/2013	matrix Dental Exams are to be conducted	
Chapter 5 (CIES) 3. Agency Requirements	annually. No evidence of exam was found.	
H. Consumer Records Policy: All Provider		
Agencies must maintain at the administrative	 Individual #6 - As indicated by the DDSD file 	
office a confidential case file for each individual.	matrix Dental Exams are to be conducted	
Provider agency case files for individuals are	annually. No evidence of exam was found.	
required to comply with the DDSD Consumer		
Records Policy.	 Individual #7 - As indicated by the DDSD file 	
	matrix Dental Exams are to be conducted	
Chapter 6 (CCS) 3. Agency Requirements:	annually. No evidence of exam was found.	
G. Consumer Records Policy: All Provider		
Agencies shall maintain at the administrative	° Individual #8 - As indicated by the DDSD file	
office a confidential case file for each individual.	matrix Dental Exams are to be conducted	
Provider agency case files for individuals are	annually. No evidence of exam was found.	
required to comply with the DDSD Individual		
Case File Matrix policy.	 Individual #9 - As indicated by the DDSD file 	
	matrix Dental Exams are to be conducted	
Chapter 7 (CIHS) 3. Agency Requirements:	annually. No evidence of exam was found	
E. Consumer Records Policy: All Provider		
Agencies must maintain at the administrative	Vision Exam	
office a confidential case file for each individual.	 Individual #2 - As indicated by the DDSD file 	
Provider agency case files for individuals are	matrix Vision Exams are to be conducted	
required to comply with the DDSD Individual	every other year. No evidence of exam was	
Case File Matrix policy.	found.	
Chapter 11 (FL) 3. Agency Requirements:		
D. Consumer Records Policy: All Family	 Individual #3 - As indicated by the DDSD file 	
Living Provider Agencies must maintain at the	matrix Vision Exams are to be conducted	
administrative office a confidential case file for	every other year. No evidence of exam was	
each individual. Provider agency case files for	found.	
individuals are required to comply with the		
DDSD Individual Case File Matrix policy.	 Individual #4 - As indicated by the DDSD file 	
	matrix Vision Exams are to be conducted	
Chapter 12 (SL) 3. Agency Requirements:	every other year. No evidence of exam was	
D. Consumer Records Policy: All Living	found.	
Supports- Supported Living Provider Agencies		
must maintain at the administrative office a	 Individual #5 - As indicated by the DDSD file 	
confidential case file for each individual.	matrix Vision Exams are to be conducted	
Provider agency case files for individuals are	every other year. No evidence of exam was	
	found.	

meeting and submitted to the Case Manager		
and all other IDT Members. A revised HAT is		
required to also be submitted whenever the		
individual's health status changes significantly.		
For individuals who are newly allocated to the		
DD Waiver program, the HAT may be		
completed within 2 weeks following the initial		
ISP meeting and submitted with any strategies		
and support plans indicated in the ISP, or		
within 72 hours following admission into direct		
services, whichever comes first.		
(2) Each individual will have a Health Care		
Coordinator, designated by the IDT. When the		
individual's HAT score is 4, 5 or 6 the Health		
Care Coordinator shall be an IDT member,		
other than the individual. The Health Care		
Coordinator shall oversee and monitor health		
care services for the individual in accordance		
with these standards. In circumstances where		
no IDT member voluntarily accepts designation		
as the health care coordinator, the community		
living provider shall assign a staff member to		
this role.		
(3) For each individual receiving Community		
Living Services, the provider agency shall		
ensure and document the following:		
(a)Provision of health care oversight		
consistent with these Standards as		
detailed in Chapter One section III E:		
Healthcare Documentation by Nurses For		
Community Living Services, Community Inclusion Services and Private Duty		
Nursing Services.		
b) That each individual with a score of 4, 5,		
or 6 on the HAT, has a Health Care Plan		
developed by a licensed nurse.		
(c) That an individual with chronic		
condition(s) with the potential to		
exacerbate into a life threatening		
condition, has Crisis Prevention/		
Intervention Plan(s) developed by a		

licensed nurse or other appropriate		7
professional for each such condition.		
(4) That an average of 3 hours of documented		
nutritional counseling is available annually, if		
recommended by the IDT.		
(5) That the physical property and grounds are		
free of hazards to the individual's health and		
safety.		
(6) In addition, for each individual receiving		
Supported Living or Family Living Services, the		
provider shall verify and document the		
following:		
(a)The individual has a primary licensed		
physician;		
(b)The individual receives an annual		
physical examination and other		
examinations as specified by a licensed		
physician;		
(c) The individual receives annual dental		
check-ups and other check-ups as specified by a licensed dentist;		
(d)The individual receives eye examinations		
as specified by a licensed optometrist or		
ophthalmologist; and		
(e)Agency activities that occur as follow-up		
to medical appointments (e.g. treatment,		
visits to specialists, changes in		
medication or daily routine).		
medication of daily rodancy.		
	1	

Tag # 1A03 CQI System	Standard Level Deficiency		
Tag # 1A03 CQI SystemSTATE OF NEW MEXICO DEPARTMENT OFHEALTH DEVELOPMENTAL DISABILITIESSUPPORTS DIVISION PROVIDERAGREEMENT: ARTICLE 17. PROGRAMEVALUATIONSd. PROVIDER shall have a Quality Managementand Improvement Plan in accordance with thecurrent MF Waiver Standards and/or the DDWaiver Standards specified by theDEPARTMENT. The Quality Management andImprovement Plan for DD Waiver Providersmust describe how the PROVIDER willdetermine that each waiver assurance andrequirement is met. The applicable assurancesand requirements are: (1) level of caredetermination; (2) service plan; (3) qualifiedproviders; (4) health and welfare; (5)administrative authority; and, (6) financialaccountability. For each waiver assurance, thisdescription must include:i. Activities or processes related to discovery,i.e., monitoring and recording the findings.	 Based on record review, the Agency did not implement their Continuous Quality Management System as required by standard. Review of the Agency's CQI Plan revealed the following: The Agency's CQI Plan did not contain the following components: a. Implementation of ISPs: extent to which services are delivered in accordance with ISPs and associated support plans with WDSI including the type, scope, amount, 	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance;	 outcomes; (CIES only) Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; (CCS, CIHS, IMLS only) 		
 ii. The entities or individuals responsible for conducting the discovery/monitoring processes; 	b. Analysis of General Events Reports data in Therap;		
iii. The types of information used to measure performance; and,	 c. Compliance with Caregivers Criminal History Screening requirements; 		
 iv. The frequency with which performance is measured. 	 d. Compliance with Employee Abuse Registry requirements; 		

Developmental Disabilities (DD) Waiver Service		
Standards effective 11/1/2012 revised 4/23/2013	e. Compliance with DDSD training	
CHAPTER 5 (CIES) 3. Agency Requirements:	requirements;	
J. Quality Assurance/Quality Improvement	(Defference/Transformer definition) have	
(QA/QI) Program: Agencies must develop and	 Patterns/Trends of reportable incidents; 	
maintain an active QA/QI program in order to	n Deculto of improvement exting taken in	
assure the provision of quality services. This	g. Results of improvement actions taken in	
includes the development of a QA/QI plan, data	previous quarters;	
gathering and analysis, and routine meetings to analyze the results of OA/OI activities	b. Sufficiency of staff coverage:	
analyze the results of QA/QI activities. 1. Development of a QA/QI plan: The quality	h. Sufficiency of staff coverage;	
management plan is used by an agency to	i. Action taken regarding individual	
continually determine whether the agency is	grievances;	
performing within program requirements,	gilevances,	
achieving desired outcomes and identifying	j. Presence and completeness of required	
opportunities for improvement. The quality	documentation;	
management plan describes the process the		
Provider Agency uses in each phase of the	k. Significant program changes.	
process: discovery, remediation and	ni eiginitean program enangeei	
improvement. It describes the frequency, the	I. A description of how data collected as part	
source and types of information gathered, as	of the agency's QA/QI Plan was used;	
well as the methods used to analyze and	what quality improvement initiatives were	
measure performance. The quality	undertaken and what were the results of	
management plan should describe how the data	those efforts, including discovery and	
collected will be used to improve the delivery of	remediation of any service delivery	
services and methods to evaluate whether	deficiencies discovered through the QA/QI	
implementation of improvements are working.	process; and (CIES, CCS, CIHS, FL, SL,	
	IMLS, ANS)	
2. Implementing a QA/QI Committee: The		
QA/QI committee must convene on at least a	NOTE: The Continuous Quality Improvement	
quarterly basis and as needed to review service	Plan provided by the agency was only a formal	
reports, to identify any deficiencies, trends,	feedback survey for clients and their guardians	
patterns or concerns as well as opportunities for	to fill out.	
quality improvement. The QA/QI meeting must		
be documented. The QA/QI review should		
address at least the following:		
a. Implementation of ISPs: extent to which services are delivered in accordance with ISPs		
and associated support plans with WDSI including the type, scope, amount, duration		
and frequency specified in the ISP as well as		
and nequency specified in the ISF as well as		

effectiveness of such implementation as	
indicated by achievement of outcomes;	
indicated by achievement of outcomes,	
3. The Provider Agency must complete a QA/QI	
report annually by February 15 th of each	
calendar year or as otherwise requested by	
DOH. The report must be kept on file at the	
agency, made available for review by DOH and	
upon request from DDSD; the report must be	
submitted to the relevant DDSD Regional	
Offices. The report will summarize:	
a. Analysis of General Events Reports data in	
Therap;	
b. Compliance with Caregivers Criminal History	
Screening requirements;	
c. Compliance with Employee Abuse Registry	
requirements;	
d. Compliance with DDSD training	
requirements;	
e. Patterns of reportable incidents;	
f. Results of improvement actions taken in	
previous quarters;	
g. Sufficiency of staff coverage;	
h. Effectiveness and timeliness of	
implementation of ISPs, and associated	
support including trends in achievement of	
individual desired outcomes;	
i. Results of General Events Reporting data	
analysis;	
j. Action taken regarding individual grievances;	
k. Presence and completeness of required	
documentation;	
I. A description of how data collected as part of	
the agency's QA/QI Plan was used; what	
quality improvement initiatives were	
undertaken and what were the results of	
those efforts, including discovery and	
remediation of any service delivery	
deficiencies discovered through the QA/QI	
process; and	
m. Significant program changes.	

CHAPTER 6 (CCS) 3. Agency Requirements:		
I. Quality Assurance/Quality Improvement		
(QA/QI) Program: Agencies must develop and		
maintain an active QA/QI program in order to		
assure the provision of quality services. This		
includes the development of a QA/QI plan, data		
gathering and analysis, and routine meetings to		
analyze the results of QI activities.		
1. Development of a QI plan: The quality		
management plan is used by an agency to		
continually determine whether the agency is		
performing within program requirements,		
achieving desired outcomes and identifying		
opportunities for improvement. The quality		
management plan describes the process the		
Provider Agency uses in each phase of the		
process: discovery, remediation and		
improvement. It describes the frequency, the		
source and types of information gathered, as		
well as the methods used to analyze and		
measure performance. The quality		
management plan should describe how the data		
collected will be used to improve the delivery of services and methods to evaluate whether		
implementation of improvements are working.		
2. Implementing a QI Committee: The QA/QI		
committee shall convene at least quarterly and		
as needed to review service reports, to identify		
any deficiencies, trends, patterns or concerns as		
well as opportunities for quality improvement.		
The QA/QI meeting shall be documented. The		
QA/QI review should address at least the		
following:		
a. The extent to which services are delivered in		
accordance with ISPs, associated support		
plans and WDSI including the type, scope,		
amount, duration and frequency specified in		
the ISP as well as effectiveness of such		

implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data: c. Compliance with Engloyers Criminal History Screening requirements; d. Compliance with DDSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QAVQI report nurularly by February 15% of each year, or as otherwise requested by DOH. The report must be explore file at the agency: made available for review by DOH and upon request from DDSD Regional Offices. The report will summarize: b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of Individual grievances; e. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completenees of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement infuliatives were undertaken and what were the results of those efforts, including discoverage through the QI process; and S. Significant program changes.		
b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with DDSD training requirements; e. Compliance with DDSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QA/QI report annually by February 15 th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trands in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and	implementation as indicated by achievement	
 c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements; e. Compliance with DSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QAQI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality implorment thistory SI plan was used; what quality implorment initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and 	of outcomes;	
 c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements; e. Compliance with DSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QAQI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality implorment thistory SI plan was used; what quality implorment initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and 	b. Analysis of General Events Reports data:	
Screening requirements: d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QA/QI report annually by February 15 th of each year, or as otherwise requested by DOH. The report must be kepton file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what qualify improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QA/QI report annually by February 15 th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD hereport must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
 requirements; c. Compliance with DDSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DDH and upon request from DDSD the report must be submitted to the relevant DDSD the regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's OI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the OI process; and 		
 e. Compliance with DDSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on flie at the agency, made available for review by DOH and upon request from DDSD he report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and 		
requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QA/QI report annually by February 15° of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's OI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QA/QI report annually by February 15 th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QA/QI report annually by February 15 th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be kept on the submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
previous quarters. 3. The Provider Agencies must complete a QA/QI report annually by February 15 th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of 159s, associated support plans, and WDSI, including trends in achticitency of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
 3. The Provider Agencies must complete a GA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and 		
QA/QI report annually by February 15 th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required document initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and	previous quarters.	
QA/QI report annually by February 15 th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required document initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		l
year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and	available for review by DOH and upon request	
summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and	from DDSD the report must be submitted to the	
summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and	relevant DDSD Regional Offices. The report will	
 b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and 		
 b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and 	a. Sufficiency of staff coverage;	
 implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and 		
plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
 achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and 		
 c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and 		
 analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and 		
 d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and 		
 e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and 		
documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and	,	
improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
service delivery deficiencies discovered through the QI process; and		
through the QI process; and		
g. Significant program changes.		
	g. Significant program changes.	

CHAPTER 7 (CIHS) 3. Agency Requirements:	
G. Quality Assurance/Quality Improvement	
(QA/QI) Program: Agencies must develop and	
maintain an active QA/QI program in order to	
assure the provision of quality services. This	
includes the development of a QA/QI plan, data	
gathering and analysis, and routine meetings to	
analyze the results of QA/QI activities.	
1. Development of a QA/QI plan: The quality	
management plan is used by an agency to	
continually determine whether the agency is	
performing within program requirements,	
achieving desired outcomes and identifying	
opportunities for improvement. The quality	
management plan describes the process the	
Provider Agency uses in each phase of the	
process: discovery, remediation and	
improvement. It describes the frequency, the	
source and types of information gathered, as	
well as the methods used to analyze and	
measure performance. The quality	
management plan should describe how the data	
collected will be used to improve the delivery of	
services and methods to evaluate whether	
mplementation of improvements are working.	
inprovonition de la martine de la montang.	
2. Implementing a QA/QI Committee: The	
QA/QI committee shall convene on at least a	
quarterly basis and as needed to review monthly	
service reports, to identify any deficiencies,	
rends, patterns or concerns as well as	
opportunities for quality improvement. The	
QA/QI meeting must be documented. The	
QA/QI review should address at least the	
ollowing:	
,	
a. Implementation of ISPs: The extent to	
which services are delivered in accordance	
with ISPs and associated support plans	
and/or WDSI including the type, scope,	
amount, duration and frequency specified in	

the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;		
b. Analysis of General Events Reports data;		
 Compliance with Caregivers Criminal History Screening requirements; 		
 Compliance with Employee Abuse Registry requirements; 		
 Compliance with DDSD training requirements; 		
f. Patterns of reportable incidents; and		
 Results of improvement actions taken in previous quarters. 		
3. The Provider Agency must complete a QA/QI report annually by February 15 th of each calendar year, or as otherwise request by DOH. The report must be kept on file at the agency, made available for review by DOH and, upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:		
a. Sufficiency of staff coverage;		
 Effectiveness and timeliness of implementation of ISPs and associated support plans and/or WDSI, including trends in achievement of individual desired outcomes; 		
 Results of General Events Reporting data analysis; 		
d. Action taken regarding individual grievances;		

e. Presence and completeness of required documentation;		
f. A description of how data collected as part of the agency's QA/QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and		
g. Significant program changes.		
CHAPTER 11 (FL) 3. Agency Requirements: H. Quality Improvement/Quality Assurance (QA/QI) Program: Family Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities. 1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.		

	2. Implementing a QA/QI Committee: The
	QA/QI committee must convene on at least a
	quarterly basis and as needed to review monthly
	service reports, to identify any deficiencies,
	trends, patterns or concerns as well as
	opportunities for quality improvement. The
	QA/QI meeting must be documented. The
	QA/QI review should address at least the
	following:
	a. The extent to which services are delivered in
	accordance with the ISP including the type,
	scope, amount, duration and frequency
	specified in the ISP as well as effectiveness
	of such implementation as indicated by
	achievement of outcomes;
	b. Analysis of General Events Reports data;
	c. Compliance with Caregivers Criminal History
	Screening requirements;
	d. Compliance with Employee Abuse Registry
	requirements;
	e. Compliance with DDSD training
	requirements;
	f. Patterns in reportable incidents; and
	g. Results of improvement actions taken in
	previous quarters.
	3. The Provider Agency must complete a QA/QI
	report annually by February 15 th of each year, or
	as otherwise requested by DOH. The report
	must be kept on file at the agency, made
	available for review by DOH and upon request
	from DDSD; the report must be submitted to the
	relevant DDSD Regional Offices. The report will
	summarize:
	a. Sufficiency of staff coverage;
	b. Effectiveness and timeliness of
	implementation of ISPs, including trends in
	achievement of individual desired outcomes;
	c. Results of General Events Reporting data
	analysis, Trends in category II significant
 	events;
	 a. The extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns in reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agency must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis, Trends in category II significant

d. Detterne in medication energy		
d. Patterns in medication errors;		
e. Action taken regarding individual grievances;		
f. Presence and completeness of required		
documentation;		
g. A description of how data collected as part		
of the agency's QI plan was used;		
h. What quality improvement initiatives were		
undertaken and what were the results of		
those efforts, including discovery and		
remediation of any service delivery		
deficiencies discovered through the QI		
process; and		
i. Significant program changes.		
CHAPTER 12 (SL) 3. Agency Requirements:		
B. Quality Assurance/Quality Improvement		
(QA/QI) Program: Supported Living Provider		
Agencies must develop and maintain an active		
QA/QI program in order to assure the provision		
of quality services. This includes the		
development of a QA/QI plan, data gathering		
and analysis, and routine meetings to analyze		
the results of QA/QI activities.		
1. Development of a QA/QI plan: The quality		
management plan is used by an agency to		
continually determine whether the agency is		
performing within program requirements, achieving desired outcomes and identifying		
opportunities for improvement. The quality		
management plan describes the process the		
Provider Agency uses in each phase of the		
process: discovery, remediation and		
improvement. It describes the frequency, the		
source and types of information gathered, as		
well as the methods used to analyze and		
measure performance. The quality		
management plan should describe how the data		
collected will be used to improve the delivery of		
services and methods to evaluate whether		
implementation of improvements are working.		
in protonionio are working.		

2. Implementing a OA/OI Committee: The		
2. Implementing a QA/QI Committee: The		
QA/QI committee must convene on at least a		
quarterly basis and as needed to review monthly		
service reports, to identify any deficiencies,		
trends, patterns, or concerns as well as		
opportunities for quality improvement. The		
QA/QI meeting must be documented. The		
QA/QI review should address at least the		
following:		
a. Implementation of the ISP and the extent to		
which services are delivered in accordance		
with the ISP including the type, scope,		
amount, duration, and frequency specified in		
the ISP as well as effectiveness of such		
implementation as indicated by achievement		
of outcomes;		
b. Analysis of General Events Reports data;		
c. Compliance with Caregivers Criminal History		
Screening requirements;		
d. Compliance with Employee Abuse Registry		
requirements;		
e. Compliance with DDSD training		
requirements;		
f. Patterns in reportable incidents; and		
g. Results of improvement actions taken in		
previous quarters.		
2. The Provider Agency must complete a QA/QI		
report annually by February 15 th of each		
calendar year, or as otherwise requested by		
DOH. The report must be kept on file at the		
agency, made available for review by DOH, and		
upon request from DDSD the report must be		
submitted to the relevant DDSD Regional		
Offices. The report will summarize:		
a. Sufficiency of staff coverage;		
b. Effectiveness and timeliness of		
implementation of ISPs, including trends in		
achievement of individual desired outcomes;		

c. Results of General Events Reporting data	
analysis, Trends in Category II significant	
events;	
d. Patterns in medication errors;	
e. Action taken regarding individual grievances;	
f. Presence and completeness of required	
documentation;	
g. A description of how data collected as part of	
the agency's QA/QI plan was used, what	
quality improvement initiatives were	
undertaken, and the results of those efforts,	
including discovery and remediation of any	
service delivery deficiencies discovered	
through the QI process; and	
h. Significant program changes.	
CHAPTER 13 (IMLS) 3. Service	
Requirements: F. Quality Assurance/Quality	
Improvement (QA/QI) Program: Agencies	
must develop and maintain an active QA/QI	
program in order to assure the provision of	
quality services. This includes the development	
of a QA/QI plan, data gathering and analysis,	
and routine meetings to analyze the results of QI	
activities.	
1. Development of a QI plan: The quality	
management plan is used by an agency to	
continually determine whether the agency is	
performing within program requirements,	
achieving desired outcomes and identifying	
opportunities for improvement. The quality	
management plan describes the process the	
Provider Agency uses in each phase of the	
process: discovery, remediation and	
improvement. It describes the frequency, the	
source and types of information gathered, as	
well as the methods used to analyze and	
measure performance. The quality	
management plan should describe how the data	
collected will be used to improve the delivery of	

services and methods to evaluate whether		
implementation of improvements are working.		
2. Implementing a QA/QI Committee: The		
QA/QI committee shall convene on at least on a		
quarterly basis and as needed to review service		
reports, to identify any deficiencies, trends,		
patterns or concerns, as well as opportunities for		
quality improvement. For Intensive Medical		
Living providers, at least one nurse shall be a		
member of this committee. The QA meeting		
shall be documented. The QA review should		
address at least the following:		
 Implementation of the ISPs, including the 		
extent to which services are delivered in		
accordance with the ISPs and associated		
support plans and /or WDSI including the type,		
scope, amount, duration, and frequency		
specified in the ISPs as well as effectiveness		
of such implementation as indicated by		
achievement of outcomes;		
 b. Trends in General Events as defined by 		
DDSD;		
c. Compliance with Caregivers Criminal History		
Screening Requirements;		
d. Compliance with DDSD training requirements;		
e. Trends in reportable incidents; and		
f. Results of improvement actions taken in		
previous quarters.		
3. The Provider Agency must complete a QA/QI		
report annually by February 15 th of each		
calendar year, or as otherwise requested by		
DOH. The report must be kept on file at the		
agency, made available for review by DOH and		
upon request from DDSD; the report must be		
submitted to the relevant DDSD Regional		
Offices. The report will summarizes:		
 a. Sufficiency of staff coverage; b. Effectiveness and timeliness of 		
implementation of ISPs and associated		

Support plans and/or WDSI including trends		
in achievement of individual desired		
outcomes;		
c. Trends in reportable incidents;		
d. Trends in medication errors;		
e. Action taken regarding individual grievances;		
f. Presence and completeness of required		
documentation;		
g. How data collected as part of the agency's		
QA/QI was used, what quality improvement		
initiatives were undertaken, and what were		
the results of those efforts, including		
discovery and remediation of any service		
delivery deficiencies discovered through the		
QI process; and		
h. Significant program changes.		
5 1 5 5		
CHAPTER 14 (ANS) 3. Service		
Requirements: N. Quality Assurance/Quality		
Improvement (QA/QI) Program: Agencies		
must develop and maintain an active QA/QI		
program in order to assure the provision of		
quality services. This includes the development		
of a QA/QI plan, data gathering and analysis,		
and routine meetings to analyze the results of		
QI activities.		
1. Development of a QI plan: The quality		
management plan is used by an agency to		
continually determine whether the agency is		
performing within program requirements,		
achieving desired outcomes and identifying		
opportunities for improvement. The quality		
management plan describes the process the		
Provider Agency uses in each phase of the		
process: discovery, remediation and		
improvement. It describes the frequency, the		
source and types of information gathered, as		
well as the methods used to analyze and		
measure performance. The quality		
management plan should describe how the data		
collected will be used to improve the delivery of		

services and methods to evaluate whether		
implementation of improvements are working.		
2. Implementing a QA/QI Committee: The		
QA/QI committee shall convene on at least on a		
quarterly basis and as needed to review service		
reports, to identify any deficiencies, trends,		
patterns or concerns, as well as opportunities for		
quality improvement. For Intensive Medical		
Living providers, at least one nurse shall be a		
member of this committee. The QA meeting		
shall be documented. The QA review should		
address at least the following:		
a. Trends in General Events as defined by		
DDSD:		
b. Compliance with Caregivers Criminal History		
Screening Requirements;		
c. Compliance with DDSD training		
requirements;		
d. Trends in reportable incidents; and		
e. Results of improvement actions taken in		
previous quarters.		
previous quarters.		
3. The Provider Agency must complete a QA/QI		
report annually by February 15 th of each		
calendar year, or as otherwise requested by		
DOH. The report must be kept on file at the		
agency, made available for review by DOH and		
upon request from DDSD; the report must be		
submitted to the relevant DDSD Regional		
Offices. The report will summarizes:		
a. Sufficiency of staff coverage;		
b. Trends in reportable incidents;		
c. Trends in medication errors;		
d. Action taken regarding individual grievances;		
e. Presence and completeness of required		
documentation;		
f. How data collected as part of the agency's		
QA/QI was used, what quality improvement		
initiatives were undertaken, and what were		
the results of those efforts, including		

discovery and remediation of any service		
delivery deficiencies discovered through the		
QI process; and		
g. Significant program changes		
5 5 1 5 5		
NMAC 7.1.14.8 INCIDENT MANAGEMENT		
SYSTEM REPORTING REQUIREMENTS FOR		
COMMUNITY-BASED SERVICE PROVIDERS:		
F. Quality assurance/quality improvement		
program for community-based service		
providers: The community-based service		
provider shall establish and implement a quality		
improvement program for reviewing alleged		
complaints and incidents of abuse, neglect, or		
exploitation against them as a provider after the		
division's investigation is complete. The incident		
management program shall include written		
documentation of corrective actions taken. The		
community-based service provider shall take all		
reasonable steps to prevent further incidents. The		
community-based service provider shall provide		
the following internal monitoring and facilitating		
quality improvement program:		
(1) community-based service providers shall		
have current abuse, neglect, and exploitation		
management policy and procedures in place		
that comply with the department's requirements;		
(2) community-based service providers		
providing intellectual and developmental		
disabilities services must have a designated		
incident management coordinator in place; and		
(3) community-based service providers		
providing intellectual and developmental		
disabilities services must have an incident		
management committee to identify any		
deficiencies, trends, patterns, or concerns as		
well as opportunities for quality improvement,		
address internal and external incident reports for		
the purpose of examining internal root causes,		
and to take action on identified issues.		

Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 Chapter 5 (CIES) 3. Agency Requirements H. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to	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 the required documentation in the Individuals Agency Record as required by	Provider: State your Plan of Correction for the deficiencies cited in this tag here: \rightarrow	
 comply with the DDSD Consumer Records Policy. Chapter 6 (CCS) 2. Service Requirements. E. The agency nurse(s) for Customized Community Supports providers must provide the following services: 1. Implementation of pertinent PCP orders; ongoing oversight and monitoring of the individual's health status and medically related supports when receiving this service; 3. Agency Requirements: Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individual Case File Matrix policy. Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individual Case File Matrix policy. 	 standard for 4 of 9 individuals. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: Electronic Comprehensive Health Assessment Tool (eCHAT) (#8) Medication Administration Assessment Tool (#8) Comprehensive Aspiration Risk Management Plan: Not Found (#8) Aspiration Risk Screening Tool (#8) Special Health Care Needs: Nutritional Plan Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. Health Care Plans Constipation Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No 	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Living Supports provider must complete the e- CHAT, the Aspiration Risk Screening Tool, (ARST), and the Medication Administration Assessment Tool (MAAT) and any other assessments deemed appropriate on at least an annual basis for each individual served, upon significant change of clinical condition and upon return from any hospitalizations. In addition, the MAAT must be updated for any significant change of medication regime, change of route that requires delivery by licensed or certified staff, or when an individual has completed training designed to improve their skills to support self-administration.	 <i>Endocrine</i> Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. <i>Status of Care</i> Individual #5 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. 	
 a. For newly-allocated or admitted individuals, assessments are required to be completed within three (3) business days of admission or two (2) weeks following the initial ISP meeting, whichever comes first. 	 Medical Emergency Response Plans Endocrine Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No 	
b. For individuals already in services, the required assessments are to be completed no more than forty-five (45) calendar days and at least fourteen (14) calendar days prior to the annual ISP meeting.	 evidence of a plan found. Seizures Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. 	
 c. Assessments must be updated within three (3) business days following any significant change of clinical condition and within three (3) business days following return from hospitalization. 		
d. Other nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency,		

method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.	
e. Develop any urgently needed interim Healthcare Plans or MERPs per DDSD policy pending authorization of ongoing Adult Nursing services as indicated by health status and individual/guardian choice.	
 Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. Service Requirements. L. Training and Requirements. 5. Health Related Documentation: For each individual receiving Living Supports- Supported Living, the provider agency must ensure and document the following: 	
a. That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has a MERP developed by a licensed nurse or other appropriate professional according to the DDSD Medical Emergency Response Plan Policy, that DSP have been trained to implement such plan(s), and ensure that a copy of such plan(s) are readily available to DSP in the home;	
 b. That an average of five (5) hours of documented nutritional counseling is available annually, if recommended by the IDT and clinically indicated; 	
c. That the nurse has completed legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served, as well as all	

5	nteractions with other healthcare providers serving the individual. All interactions must be documented whether they occur by phone or in person; and
d. I	Document for each individual that:
i.	The individual has a Primary Care Provider (PCP);
ii.	The individual receives an annual physical examination and other examinations as specified by a PCP;
iii.	The individual receives annual dental check- ups and other check-ups as specified by a licensed dentist;
iv.	The individual receives a hearing test as specified by a licensed audiologist;
v.	The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and
vi.	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).
f	The agency nurse will provide the individual's team with a semi-annual nursing report that discusses the services provided and the status of the individual in the last six (6) months. This may be provided electronically or in paper format to the team no later than (2) weeks prior to the ISP and semi-annually. The Supported Living Provider Agency must ensure that activities conducted by agency nurses comply with the roles and responsibilities dentified in these standards.
	aentified in these standards. hapter 13 (IMLS) 2. Service Requirements:

C. Documents to be maintained in the agency administrative office, include:A. All assessments completed by the agency		
nurse, including the Intensive Medical Living		
Eligibility Parameters tool; for e-CHAT a printed copy of the current e-CHAT summary report shall		
suffice;		
F. Annual physical exams and annual dental exams (not applicable for short term stays);		
G. Tri-annual vision exam (Not applicable for short term stays. See Medicaid policy 8.310.6 for		
allowable exceptions for more frequent vision		
exam);		
H. Audiology/hearing exam as applicable (Not		
applicable for short term stays; See Medicaid		
policy 8.324.6 for applicable requirements);		
I. All other evaluations called for in the ISP for		
which the Services provider is responsible to arrange;		
J. Medical screening, tests and lab results (for		
short term stays, only those which occur during the		
period of the stay);		
L. Record of medical and dental appointments,		
including any treatment provided (for short term stays, only those appointments that occur during		
the stay);		
O. Semi-annual ISP progress reports and MERP reviews (not applicable for short term stays);		
P. Quarterly nursing summary reports (not applicable for short term stays);		
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider		
must maintain all the records necessary to fully		
disclose the nature, quality, amount and medical		
necessity of services furnished to an eligible		

recipient who is currently receiving or who has received services in the past. B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010 F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief description of the condition or illness. 2. A brief description of the condition or illness. 3. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e. g., avoiding allergens that flogenes and stma asthem attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personne (ICSP) and/or others to			
B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010 F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: A brief, simple description of the condition or illness. A brief description of the most likely life threatening complications that might occur and what those complications that might accur and observer. A concise list of the most important measures that may prevent the life threatening complication from asthma attack or making sure the person with diabetes has snacks with them to avoid hypogycemia). Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support tersonnel (DSP) and/or others to 			
tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010 F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DEP) and/or others to			
includes results of laboratory and radiology procedures or progress following therapy or treatment. Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010 F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications the most interview the might occur ing (e.g., avoiding allergen an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to	B. Documentation of test results: Results of		
procedures or progress following therapy or treatment. Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010 F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to	tests and services must be documented, which		
treatment. Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010 F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief description of the condition or illness. 2. A brief description of the condition or illness. 3. A concise list of the most likely life threatening complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from courring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypogycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to	includes results of laboratory and radiology		
Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010 F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: A brief, simple description of the condition or illness. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycernia). Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to 			
Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010 F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to Interval Interval	treatment.		
Emergency Response Plan Policy MERP-001 eff.8/1/2010 F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to	Department of Health Developmental		
eff.8/r/2010 F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to			
 F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or iilness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to 		1	
free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to	eff.8/1/2010		
free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to	F. The MERP shall be written in clear jargon		
following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to			
 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to 			
 illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to 		r	
threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to			
 what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to 			
observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to			
 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to 			
that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to			
 complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to 		PS	
 allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to 			
sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to			
them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to			
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to			
regarding the actions to be taken by direct support personnel (DSP) and/or others to			
support personnel (DSP) and/or others to			
	support personnel (DSP) and/or others to		
	intervene in the emergency, including criteria for	or	
when to call 911.			
5. Emergency contacts with phone numbers.			
6. Reference to whether the individual has			
advance directives or not, and if so, where the			
advance directives are located.	auvance unectives are located.		
Developmental Disabilities (DD) Waiver Service	Developmental Disabilities (DD) Waiver Service		
Standards effective 4/1/2007			
CHAPTER 1 II. PROVIDER AGENCY			
REQUIREMENTS: D. Provider Agency Case	REQUIREMENTS: D. Provider Agency Case		

File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements1, 2, 3, 4, 5, 6, 7, 8, CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities (2) Health related plans and (4) General Nursing Documentation Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007	
CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS B. IDT Coordination (2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.	

Tag # 1A27	Standard Level Deficiency		
Incident Mgt. Late and Failure to Report			
NMAC 7.1.14 ABUSE, NEGLECT,	Based on the Incident Management Bureau's	Provider:	
EXPLOITATION, AND DEATH REPORTING,	Late and Failure Reports, the Agency did not	State your Plan of Correction for the	
TRAINING AND RELATED REQUIREMENTS	report suspected abuse, neglect, or exploitation,	deficiencies cited in this tag here: \rightarrow	
FOR COMMUNITY PROVIDERS	unexpected and natural/expected deaths; or		
	other reportable incidents to the Division of		
NMAC 7.1.14.8 INCIDENT MANAGEMENT	Health Improvement, as required by regulations		
SYSTEM REPORTING REQUIREMENTS FOR	for 3 of 9 individuals.		
COMMUNITY-BASED SERVICE PROVIDERS:			
	Individual #5		
A. Duty to report:	 Incident date 12/4/2014. Allegation was 		
(1) All community-based providers shall	Neglect. Incident report was received on		
immediately report alleged crimes to law	12/4/2014. Late Reporting. IMB Late and		
enforcement or call for emergency medical	Failure Report indicated incident of Neglect		
services as appropriate to ensure the safety of	was "Confirmed."		
consumers.		Provider:	
(2) All community-based service providers, their	Individual # 6	Enter your ongoing Quality Assurance/Quality	
employees and volunteers shall immediately call	 Incident date 12/4/2014. Allegation was 	Improvement processes as it related to this tag	
the department of health improvement (DHI)	Neglect. Incident report was received on	number here: \rightarrow	
hotline at 1-800-445-6242 to report abuse,	12/4/2014. Late Reporting. IMB Late and		
neglect, exploitation, suspicious injuries or any	Failure Report indicated incident of Neglect		
death and also to report an environmentally	was "Confirmed."		
hazardous condition which creates an immediate			
threat to health or safety.	Individual #8		
B. Reporter requirement. All community-based	 Incident date 12/4/2014. Allegation was 		
service providers shall ensure that the	Neglect. Incident report was received on		
employee or volunteer with knowledge of the	12/4/2014. Late Reporting. IMB Late and		
alleged abuse, neglect, exploitation, suspicious	Failure Report indicated incident of Neglect		
injury, or death calls the division's hotline to	was "Confirmed."		
report the incident.			
C. Initial reports, form of report, immediate			
action and safety planning, evidence			
preservation, required initial notifications:			
(1) Abuse, neglect, and exploitation,			
suspicious injury or death reporting: Any			
person may report an allegation of abuse,			
neglect, or exploitation, suspicious injury or a			
death by calling the division's toll-free hotline			
number 1-800-445-6242. Any consumer,			

	1	
family member, or legal guardian may call the		
division's hotline to report an allegation of		
abuse, neglect, or exploitation, suspicious		
injury or death directly, or may report through		
the community-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		
providers: The responsible community-based		
service provider shall notify the consumer's		
case 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		

Tag # 1A28.2 Incident Mgt. System - Parent/Guardian	Condition of Participation Level Deficiency		
Training	,		
7.1.14.9INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: A. General: All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. E. Consumer and guardian orientation packet: Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.	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 provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 5 of 9 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: • Parent/Guardian Incident Management Training (Abuse, Neglect and Exploitation) (#2, 3, 6, 7, 8)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →]	

Tag # 1A29 Complaints / Grievances Acknowledgement	Standard Level Deficiency		
NMAC 7.26.3.6 A These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC].	provide documentation, the complaint procedure	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
 NMAC 7.26.3.13 Client Complaint Procedure Available. A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] NMAC 7.26.4.13 Complaint Process: A. (2). The service provider's complaint or grievance procedure shall provide, at a minimum, that: (a) the client is notified of the 		Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
service provider's complaint or grievance procedure			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
		ists to assure that claims are coded and pa	id for in
accordance with the reimbursement meth			
Tag # IS30	Standard Level Deficiency		
Customized Community Supports			
Reimbursement			
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 6 (CCS) 4. REIMBURSEMENT A. Required Records: All Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 3 of 4 individuals. Individual #4 June 2015 • The Agency billed 156 units of Customized	Provider: State your Plan of Correction for the deficiencies cited in this tag here: \rightarrow	
Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, nature of services, and length of a session of service billed.	Community Supports (group) (T2021 HB UA) from 6/17/2015 through 6/24/2015. Documentation received accounted for 152 units.		
1. The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit billed, the record shall contain the following:	The Agency billed 216 units of Customized Community Supports (group) (T2021 HB UA) from 6/25/2015 through 7/7/2015. Documentation received accounted for 190 units.	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
a. Date, start and end time of each service encounter or other billable service interval;	Individual # 6 July 2015 • The Agency billed 54 units of Customized Community Supports (group) (T2021 HB		
b. A description of what occurred during the encounter or service interval; and	U5) on 7/7/2015. Documentation received accounted for 23 units.		
c. The signature or authenticated name of staff providing the service.	The Agency billed 117 units of Customized Community Supports (group) (T2021 HB		
B. Billable Unit:	U5) from 7/8/2015 through 7/14/2015. Documentation received accounted for 98 units		

 The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group. The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Customized Community Supports without prior approval from DDSD. The billable unit for Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit. (There is a separate rate established for individuals who require one- to-one (1:1) support either in the community or in a group day setting due to behavioral challenges (NM DDW group G). The billable unit for Fiscal Management for Adult Education is dollars charged for each class including a 10% administrative processing fee. Billable Activities: 1. All DSP activities that are: 	 Individual #8 June 2015 The Agency billed 82 units of Customized Community Supports (individual) (H2021 HB U1) from 5/20/2015 to 6/9/2015. Documentation received accounted for 76 units. The Agency billed 58 units of Customized Community Supports (individual) (H2021 HB U1) from 6/10/2015 to 6/23/2015. Documentation received accounted for 36 units. July 2015 The Agency billed 20 units of Customized Community Supports (individual) (H2021 HB U1) from 7/8/2015 to 7/14/2015. No documentation was found for 07/08/2015 through 07/14/2015 to justify the 20 units billed. The Agency billed 40 units of Customized Community Supports (individual) (H2021 HB U1) from 7/15/2015 to 7/21/2015. Documentation received accounted for 20 units 	
 b. Described in the individual's approved ISP; c. Provided in accordance with the Scope of Services; and 		

 Activities included in billable services, activities or situations. 	
 Purchase of tuition, fees, and/or related materials associated with adult education opportunities as related to the ISP Action Plan and Outcomes, not to exceed \$550 including administrative processing fee. 	
 Customized Community Supports can be included in ISP and budget with any other services. 	
MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.	



Date:

January 26, 2016

To: Provider: Address: State/Zip:	Manish Gaur People Center Services, LLC 1807 2nd Street, Unit 82 Santa Fe, New Mexico, 87505
E-mail Address:	manishgaur@netzero.com
Region: Survey Date: Program Surveyed:	Northeast August 24 – 28, 2015 Developmental Disabilities Waiver
Service Surveyed:	2012: Inclusion Supports (Customized Community Supports, Community Integrated Employment Services) 2007: Community Inclusion (Adult Habilitation)
Survey Type:	Routine

Dear Mr. Gaur;

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda Plan of Correction Coordinator Quality Management Bureau/DHI

Q.16.1.DDW.242907870.2.RTN.09.16.26