

Date: April 11, 2018

To: Anna Marie Blea, Executive Director  
Provider: Phame, Inc.  
Address: 2903 Agua Fria Street, Suite B  
State/Zip: Santa Fe, New Mexico 87507

E-mail Address: [amblea@phameinc.org](mailto:amblea@phameinc.org)

Region: Northeast  
Survey Date: January 5 - 12, 2018  
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012:** Customized Community Supports, Community Integrated Employment Services  
**2007:** Adult Habilitation

Survey Type: Routine

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

Team Members: Kandis Gomez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Anna Marie Blea;

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***

- Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation

This determination is based on noncompliance 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

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

QMB Report of Findings – Phame, Inc. – Northeast Region – January 5 - 12, 2018

Survey Report #: Q.18.3.DDW.46931759.2.RTN.01.18.101



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.

During the exit interview of your on-site survey Attachment A on the Plan of Correction Process was provided to you. Please refer to Attachment A for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

**Corrective Action:**

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

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

- What is going to be done? (i.e. file reviews, periodic check with checklist, etc.)
- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORI, etc.)

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

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

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

Please be advised that there is a one-week lag period for applying payments received by check to 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,

*Lora Norby*

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

**Survey Process Employed:**

Administrative Review Start Date: January 5, 2018

Entrance Conference Date: January 8, 2018

Contact: **Phame, Inc.**  
Anna Marie Blea, Director/Owner

**DOH/DHI/QMB**  
Lora Norby, Team Lead/Healthcare Surveyor

On-site Entrance Conference Date: Agency chose to waive the Entrance Conference on January 8, 2018

Exit Conference Date: January 10, 2018

Present: **Phame, Inc.**  
Anna Marie Blea, Director/Owner

**DOH/DHI/QMB**  
Lora Norby, Healthcare Surveyor  
Kandis Gomez, AA, Healthcare Surveyor

**DDSD Northeast Office**  
Angela Pacheco, Northeast Regional Director

Administrative Locations Visited 1

Total Sample Size 10

2 - *Jackson* Class Members  
8 - *Non-Jackson* Class Members

7 - Customized Community Supports  
3 - Community Integrated Employment Services  
2 - Adult Habilitation

Persons Served Records Reviewed 10

Persons Served Interviewed 6

Persons Served Observed 1 (One individual chose not to participate in the interview process)

Persons Served Not Seen and/or Not Available 3

Direct Support Personnel Interviewed 8

Direct Support Personnel Records Reviewed 11

Service Coordinator Records Reviewed 1

Administrative Interviews 1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided

- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - Medication Administration Records
  - Medical Emergency Response Plans
  - Therapy Evaluations and Plans
  - Healthcare Documentation Regarding Appointments and Required Follow-Up
  - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement  
 DOH - Developmental Disabilities Supports Division  
 DOH - Office of Internal Audit  
 HSD - Medical Assistance Division  
 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 [AmandaE.Castaneda@state.nm.us](mailto:AmandaE.Castaneda@state.nm.us). Requests for technical assistance must be requested through your Regional DDSD Office.

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

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

##### **Required Content**

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice 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.

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

### **Completion Dates**

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

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

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

### **POC Document Submission Requirements**

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

1. Your internal documents are due within a *maximum* of 45 business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If 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 *must be annotated*; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDS Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

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

## Attachment B

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

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

*Case Management Services (Four Service Domains):*

- Plan of Care: ISP Development & Monitoring
- Level of Care
- Qualified Providers
- Health, Safety and Welfare

*Community Living Supports / Inclusion Supports (Three Service Domains):*

- Service Plans: ISP Implementation
- Qualified Provider
- Health, Safety and Welfare

### 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 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: Plan of Care ISP Development & Monitoring**

Condition of Participation:

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

Condition of Participation:

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

**Service Domain: Level of Care**

Condition of Participation:

3. **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.

**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 DDS.

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

**Service Domain: Service Plan: ISP Implementation**

Condition of Participation:

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

**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 repeat 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 and/or 6 or more Condition of Participation level deficiencies overall, as well as widespread Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

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

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

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

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

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

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

**Agency:** Phame, Inc. - Northeast Region  
**Program:** Developmental Disabilities Waiver  
**Service:** 2012: Customized Community Supports, Community Integrated Employment Services  
 2007: Adult Habilitation  
**Survey Type:** Routine  
**Survey Date:** January 5 - 12, 2018

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<b>Service Domain: Service Plans: ISP Implementation</b> - Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.			
<p><b>Tag # 1A08 Agency Case File</b></p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>Chapter 5 (CIES) 3. Agency Requirements: J. Consumer Records Policy:</b> Community Integrated Employment Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p><b>Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. Additional documentation that is required to be maintained at the administrative office includes:</p> <p>1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD.</p> <p><b>Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy:</b> All Provider Agencies must maintain at the administrative office a confidential case file for each individual.</p>	<p><b>Standard Level Deficiency</b></p> <p>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 7 of 10 Individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p><b>ISP budget forms MAD 046:</b></p> <ul style="list-style-type: none"> <li>• Not Found (#2, 5, 10)</li> <li>• Not Current (#1, 7)</li> </ul> <p><b>Current Emergency and Personal Identification Information:</b></p> <ul style="list-style-type: none"> <li>• Did not contain Health Insurance Information (#2)</li> </ul> <p><b>ISP Signature Page:</b></p> <ul style="list-style-type: none"> <li>• Not Found (#1, 2, 4, 5, 7, 10)</li> </ul> <p><b>ISP Teaching and Support Strategies:</b></p> <ul style="list-style-type: none"> <li>• Individual #2 - TSS not found for the following Work / Learn Outcome Statement/Action Steps:             <ul style="list-style-type: none"> <li>◦ "...will job search"</li> </ul> </li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

<p>Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p><b>Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy:</b> 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.</p> <p><b>Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy:</b> 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.</p> <p><b>Chapter 13 (IMLS) 2. Service Requirements: C.</b> 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)</p> <ul style="list-style-type: none"> <li>• Emergency contact information;</li> <li>• Personal identification;</li> <li>• ISP budget forms and budget prior authorization;</li> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Individual #3 - TSS not found for the following Work / Learn Outcome Statement/Action Steps:</i> <ul style="list-style-type: none"> <li>◦ "BSC will provide strategies and training around behavioral challenges that may arise from working on this outcome."</li> <li>◦ "Job coach will decrease time spent supporting/prompting ..."</li> </ul> </li> <li>• <i>Individual #5 - TSS not found for the following Work/learn Outcome Statement / Action Steps:</i> <ul style="list-style-type: none"> <li>◦ "With staff assistance ... will find an art project she is interested in on her IPAD."</li> <li>◦ "...will use verbal communication and modeling to show peers how to complete the project."</li> </ul> </li> </ul> <p><b>Documentation of Guardianship/Power of Attorney:</b></p> <ul style="list-style-type: none"> <li>• Not Found (#1, 7)</li> </ul> <p><b>Occupational Therapy Plan:</b></p> <ul style="list-style-type: none"> <li>• Not Found (#10)</li> </ul> <p><b>Physical Therapy Plan:</b></p> <ul style="list-style-type: none"> <li>• Not Current (#7)</li> </ul> <p><b>Speech Therapy Plan:</b></p> <ul style="list-style-type: none"> <li>• Not Current (#3, 7)</li> </ul>		
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<p>Written Direct Support Instructions (WDSI);</p> <ul style="list-style-type: none"> <li>• 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;</li> <li>• Copy of Guardianship or Power of Attorney documents as applicable;</li> <li>• Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays;</li> <li>• Written consent by relevant health decision maker and primary care practitioner for self-administration of medication or assistance with medication from DSP as applicable;</li> <li>• Progress notes written by DSP and nurses;</li> <li>• Signed secondary freedom of choice form;</li> <li>• Transition Plan as applicable for change of provider in past twelve (12) months.</li> </ul> <p><b>DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director’s Release: Consumer Record Requirements eff. 11/1/2012</b></p> <p><b>III. Requirement Amendments(s) or Clarifications:</b> A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director’s release. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.</p>			
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<p><b>NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b> A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.</p> <p><b>B. Documentation of test results:</b> Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.</p>			
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Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	Standard Level Deficiency		
<p><b>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP.</b> The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide</p>	<p>Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan for 5 of 10 individuals.</p> <p>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p><b>Administrative Files Reviewed:</b></p> <p><b>Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #4</p> <ul style="list-style-type: none"> <li>• According to the Work/Learn Outcome; Action Step for "...will go to the library" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2017 - 11/2017.</li> <li>• According to the Work/Learn Outcome; Action Step for "With assistance, will practice reading" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2017 - 11/2017.</li> <li>• According to the Work/Learn Outcome; Action Step for "Staff will also read to ..." is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2017 - 11/2017.</li> </ul> <p>Individual #8</p>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (<i>What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

<p>direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<ul style="list-style-type: none"> <li>• None found regarding: Fun Outcome/Action Step: "Talk with girlfriend and plan their date" for 9/2017 - 11/2017. Action step is to be completed 1 time per month.</li> <li>• None found regarding: Fun Outcome/Action Step: "Have money to go on the date" for 9/2017 - 11/2017. Action step is to be completed 1 time per month.</li> <li>• None found regarding: Fun Outcome/Action Step: "Go on date" for 9/2017 - 11/2017. Action step is to be completed 1 time per month.</li> <li>• According to the Fun Outcome; Action Step for "Assemble swimming gear" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2017 - 11/2017.</li> <li>• According to the Fun Outcome; Action Step for "Complete 20 laps in pool" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2017 - 11/2017.</li> </ul> <p>Individual #10</p> <ul style="list-style-type: none"> <li>• According to the Fun Outcome; Action Step for "...will practice her songs" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2017 - 10/2017.</li> </ul> <p><b>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p>		
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	<p>Individual #1</p> <ul style="list-style-type: none"> <li>• None found regarding: Fun Outcome/Action Step: "...will practice her song and be ready for production" for 9/2017 - 11/2017. Action step is to be completed 2 times per week</li> </ul> <p><b>Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #6</p> <ul style="list-style-type: none"> <li>• None found regarding: Work/learn Outcome/Action Step: "Will follow checklist of chores" for 9/2017 - 11/2017. Action step is to be completed 3 times per week.</li> <li>• None found regarding: Work/learn Outcome/Action Step: "Will follow time limits for each chore so she can finish cleaning building" for 9/2017 - 11/2017. Action step is to be completed 3 times per week.</li> </ul>		
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Tag # IS11 / 5I11 Reporting Requirements Inclusion Reports	Standard Level Deficiency		
<p><b>7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:</b></p> <p>C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>CHAPTER 5 (CIES) 3. Agency Requirements:</b></p> <p><b>I. Reporting Requirements:</b> The Community Integrated Employment Agency must submit the following:</p> <p>1. Progress Reports: Community Integrated Employment Services providers must submit written status reports to the individual's Case Manager and other IDT members. When reports are developed in any language other than English, it is the responsibility of the provider to translate the reports into English. These reports are due at two points in time: a mid-cycle report due on day 190 of the ISP cycle and a second summary report due two</p>	<p>Based on record review, the Agency did not complete written status reports as required for 1 of 10 individuals receiving Inclusion Services.</p> <p><b>Customized Community Supports Semi-Annual Reports:</b></p> <ul style="list-style-type: none"> <li>Individual #8 - None found for 11/2016 - 1/2017 (Term of ISP 5/19/2016 - 5/18/2017 ISP meeting held 2/17/2017) and 5/2017 - 11/2017. (Term of ISP 5/19/2017 - 5/18/2018).</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	<p>  </p>

<p>weeks prior to the annual ISP meeting that covers all progress since the beginning of the ISP cycle up to that point. These reports must contain the following written documentation:</p> <ul style="list-style-type: none"> <li>a. Written updates to the ISP Work/Learn Action Plan annually or as necessary due to change in work outcome to the case manager. These updates do not require an IDT meeting unless changes requiring team input need to be made (e.g., adding more hours to the Community Integrated Employment budget); and</li> <li>b. Written annual updates to the ISP work/learn action plan to DDS.</li> </ul> <p>2. VAP or other assessment profile to the case manager if completed externally to the ISP;</p> <p>3. initial ISP reflecting the Vocational Assessment or other assessment profile or the annual ISP with the updated VAP integrated or a copy of an external VAP if one was completed to DDS; and</p> <p>4. Reports as requested by DDS to track employment outcomes.</p> <p><b>CHAPTER 6 (CCS) 3. Agency Requirements:</b></p> <p><b>I. Reporting Requirements:</b> Progress Reports: Customized Community Supports providers must submit written status reports to the individual's Case Manager and other IDT members. When reports are developed in any language other than English, it is the responsibility of the provider to translate the reports into English. These reports are due at two points in time: a mid-cycle report due on day 190 of the ISP cycle and a second summary report due two weeks prior to the annual ISP meeting that covers all progress since the beginning of the ISP cycle up to that point. These reports must contain the following written documentation:</p> <ul style="list-style-type: none"> <li>2. Semi-annual progress reports one hundred ninety (190) days following the date of the</li> </ul>			
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<p>annual ISP, and 14 days prior to the annual IDT meeting:</p> <ul style="list-style-type: none"> <li>a. Identification of and implementation of a Meaningful Day definition for each person served;</li> <li>b. Documentation for each date of service delivery summarizing the following: <ul style="list-style-type: none"> <li>i. Choice based options offered throughout the day; and</li> <li>ii. Progress toward outcomes using age appropriate strategies specified in each individual's action steps in the ISP, and associated support plans/WDSI.</li> </ul> </li> <li>c. Record of personally meaningful community inclusion activities;</li> <li>d. Written updates, to the ISP Work/Learn Action Plan annually or as necessary due to change in work outcomes. These updates do not require an IDT meeting unless changes requiring team input need to be made; and</li> <li>e. Data related to the requirements of the Performance Contract to DDSD quarterly. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</li> </ul> <p><b>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>E. Provider Agency Reporting Requirements:</b> All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation:</p> <ul style="list-style-type: none"> <li>(1) Identification and implementation of a meaningful day definition for each person served;</li> </ul>			
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<p>(2) Documentation summarizing the following:</p> <ul style="list-style-type: none"> <li>(a) Daily choice-based options; and</li> <li>(b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP.</li> </ul> <p>(3) Significant changes in the individual's routine or staffing;</p> <p>(4) Unusual or significant life events;</p> <p>(5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;</p> <p>(6) Record of personally meaningful community inclusion;</p> <p>(7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and</p> <p>(8) Any additional reporting required by DDSD.</p>			
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Tag # IS22 / 5I22 SE Agency Case File	Standard Level Deficiency		
<p><b>New Mexico Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) DIRECTOR'S RELEASE (DR) #: 16.01.01</b>  <b>EFFECTIVE DATE:</b> January 15, 2016 Rescind Policy Number: VAP-001; Procedure Number: VAPP-001</p> <p><b>SUMMARY:</b> Effective January 15, 2016, the Department of Health/Developmental Disabilities Supports Division (DDSD) rescinded the Vocational Assessment Profile Policy (VAP-001) and Vocational Assessment Profile Procedure for Individuals on the Developmental Disabilities Waiver Who Are and Who Are Not Jackson Class Members (VAPP-001) dated July 16, 2008.</p> <p><b>II. REQUIREMENTS AND CLARIFICATIONS:</b> To replace this policy and procedure, it is the expectation that providers who support individuals on the Developmental Disabilities Waiver (DDW) complete an annual person-centered assessment. This is a requirement for all DD Waiver recipients who receive Customized Community Supports and/or Community Integrated Employment services, including Jackson Class Members who receive Community Inclusion Services. In addition, for new allocations, individuals transferring from Mi Via Waiver services to traditional DD Waiver services, or for individuals who are new to a provider or are requesting a service for the first time, a person-centered assessment shall be completed within 90 days.</p> <p>A person-centered assessment is a tool to elicit information about a person. The tool is to be used for person-centered planning and collecting information that shall be included in the Individual Service Plan (ISP). A person-centered assessment should contain, at a minimum: Information about the individual's background and current status, the individual's strengths, interests, conditions for success to integrate into the community, including conditions for job success (for individuals who are working or wish to work), and support needs for the</p>	<p>Based on record review, the Agency did not maintain a confidential case file for each individual receiving Community Integrated Employment Services / Supported Employment Services for 1 of 3 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p><b>Required Certificates and Documentation</b></p> <ul style="list-style-type: none"> <li>• Statement of earnings (#6)</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (<i>What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →  </p>	<p> </p>

<p>individual. A person-centered assessment must include individual and/or family involvement. Additionally, information from staff members who are closest to the individual and who know the individual the best should be included in the assessment.</p> <p>A career development plan should be in place for job seekers to outline the tasks needed to obtain employment. A career development plan can be a separate document or be added as an addendum to a person-centered assessment. A career development plan should have specific action steps that identifies who does what, by when. The information needs to be incorporated into the ISP as an Action Plan.</p> <p>A new person-centered assessment should be completed at least every five years. If there is a significant change in an individual's circumstance, a new assessment will be required sooner. Person-centered assessments should reviewed and be updated annually. Changes to the updated assessment should be signed and dated in order to demonstrate that the assessment was reviewed.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>CHAPTER 5 (CIES) 3. Agency Requirements</b></p> <p><b>J. Consumer Records Policy:</b> Community Integrated Employment Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</b></p> <p><b>D. Provider Agency Requirements</b></p> <p>(1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage</p>			
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laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.

(2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:

- (a) Quarterly progress reports;
- (b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD;
- (c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks including the individual, as well and a review and reporting mechanism for mutual accountability; and
- (d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<b>Service Domain: Qualified Providers - The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.</b>			
<b>Tag # 1A11.1 Transportation Training</b>	<b>Standard Level Deficiency</b>		
<p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy</b>  Training Requirements for Direct Service Agency Staff Policy <b>Eff. Date:</b> March 1, 2007</p> <p><b>II. POLICY STATEMENTS:</b> I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:</p> <ol style="list-style-type: none"> <li>1. Operating a fire extinguisher</li> <li>2. Proper lifting procedures</li> <li>3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat)</li> <li>4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)</li> <li>5. Operating wheelchair lifts (if applicable to the staff's role)</li> <li>6. Wheelchair tie-down procedures (if applicable to the staff's role)</li> <li>7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)</li> </ol> <p><b>NMAC 7.9.2 F. TRANSPORTATION: (1)</b> 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 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</p>	<p>Based on record review, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 3 of 11 Direct Support Personnel.</p> <p><b>No documented evidence was found of the following required training:</b></p> <ul style="list-style-type: none"> <li>• Transportation (#502, 503, 506)</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (<i>What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →  </p>	<p>   </p>

<p>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.</p> <p><b>(2)</b> 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:</p> <p><b>(a)</b> A state approved training program in passenger assistance and</p> <p><b>(b)</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.</p> <p><b>(c)</b> A valid New Mexico driver's license for the type of vehicle being operated consistent with State of New Mexico requirements.</p> <p><b>(3)</b> Each regulated facility and agency shall establish and enforce written policies (including training) and procedures for employees who provide assistance to clients with boarding or alighting from motor vehicles.</p> <p><b>(4)</b> Each regulated facility and agency shall establish and enforce written policies (including training and procedures for employees who operate motor vehicles to transport clients.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p>			
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**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

<p>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.</p> <p><b>CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:</b> 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.</p> <p><b>CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.</b> 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;</p>			
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Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency		
<p><b>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:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>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.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p> <p>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.</p> <p>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</p> <p>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</p> <p>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.</p> <p>H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.</p> <p>I. Staff providing direct services shall complete safety training within the first thirty (30) days of</p>	<p>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 3 of 11 Direct Support Personnel.</p> <p>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed as required:</p> <p><b>Assisting with Medication Delivery</b></p> <ul style="list-style-type: none"> <li>• Expired (#502)</li> </ul> <p><b>CPR</b></p> <ul style="list-style-type: none"> <li>• Not Found (#504, 507)</li> </ul> <p><b>First Aid</b></p> <ul style="list-style-type: none"> <li>• Not Found (#504, 507)</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →  </p>	<p> </p>

<p>employment and before working alone with an individual receiving service.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.</b> All Community Inclusion Providers must provide staff training in accordance with the DDS policy T-003: Training Requirements for Direct Service Agency Staff Policy.</p> <p><b>CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1.</b> All Customized Community Supports Providers shall provide staff training in accordance with the DDS Policy T-003: Training Requirements for Direct Service Agency Staff Policy;</p> <p><b>CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:</b> The Provider Agency must report required personnel training status to the DDS Statewide Training Database as specified in the DDS Policy T-001: Reporting and Documentation of DDS Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDS Policy T-003: Training Requirements for Direct Service Agency Staff Policy</p> <p><b>CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:</b> 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</p>			
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<p>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.</p> <p><b>CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:</b> 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.</p> <p><b>CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.</b> 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;</p>			
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Tag # 1A22 Agency Personnel Competency	Standard Level Deficiency		
<p><b>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:</b></p> <p>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) for each individual serviced.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements:</b> 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. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.</p> <p><b>CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows:</b> 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;</p> <p><b>CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:</b> The Provider Agency must report required personnel training</p>	<p>Based on interviews, the Agency did not ensure training competencies were met for 1 of 8 Direct Support Personnel</p> <p><b>When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #503 stated, "No, I don't think so." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #2)</li> </ul> <p><b>When DSP were asked if the individual had a Behavioral Crisis Intervention Plan and if so, what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #503 stated, "No, I don't think so." According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #2)</li> </ul> <p><b>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #503 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Body Mass Index, Constipation and Diabetes (Individual #2)</li> </ul> <p><b>When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:</b></p>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (<i>What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

<p>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.</p> <p><b>CHAPTER 11 (FL) 3. Agency Requirements</b>  <b>B. Living Supports- Family Living Services</b>  <b>Provider Agency Staffing Requirements: 3. Training:</b>  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</p>	<ul style="list-style-type: none"> <li>• DSP #503 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Diabetes. (Individual #2)</li> </ul> <p><b>When DSP were asked if they had received training on the Individual's Diabetes, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #503 stated, "No." As indicated by the Individual Specific Training section of the ISP Day staff are required to receive training on Diabetes. (Individual #2)</li> </ul>		
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<p>Documentation for DDS Training Requirements.</p> <p>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.</p> <p><b>CHAPTER 12 (SL) 3. Agency Requirements</b>  <b>B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:</b>  A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDS 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 DDS Statewide Training Database as specified in DDS Policy T-001: Reporting and Documentation for DDS Training Requirements.</p>			
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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 Caregiver Criminal History Screening	Standard Level Deficiency		
<p><b>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:</b>  <b>F. Timely Submission:</b> Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</p> <p><b>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:</b>  <b>A. Prohibition on Employment:</b> A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</p> <p>(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.</p> <p>(2) An applicant's, caregiver's or hospital caregiver's failure to respond within the required timelines regarding the final disposition of the</p>	<p>Based on record review, the Agency did not maintain documentation indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 1 of 12 Agency Personnel.</p> <p><b>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</b></p> <p><b>Direct Support Personnel (DSP):</b></p> <ul style="list-style-type: none"> <li>• #504 – Date of hire 9/22/2017.</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (<i>What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

<p>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.</p> <p><b>(3)</b> 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.</p> <p><b>B. Employment Pending Reconsideration Determination:</b> 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.</p>			
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<p><b>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.</b> The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:</p> <ul style="list-style-type: none"> <li><b>A.</b> homicide;</li> <li><b>B.</b> trafficking, or trafficking in controlled substances;</li> <li><b>C.</b> kidnapping, false imprisonment, aggravated assault or aggravated battery;</li> <li><b>D.</b> rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;</li> <li><b>E.</b> crimes involving adult abuse, neglect or financial exploitation;</li> <li><b>F.</b> crimes involving child abuse or neglect;</li> <li><b>G.</b> crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</li> <li><b>H.</b> an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</li> </ul>			
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Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	Standard Level Deficiency		
<p><b>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:</b> Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p><b>A. Provider requirement to inquire of registry.</b> A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p><b>B. Prohibited employment.</b> 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.</p> <p><b>D. Documentation of inquiry to registry.</b> 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</p>	<p>Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 2 of 12 Agency Personnel.</p> <p><b>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:</b></p> <p><b>Direct Support Personnel (DSP):</b></p> <ul style="list-style-type: none"> <li>• #500 - Date of hire 7/30/2016, completed 8/2/2016.</li> <li>• #504 - Date of hire 9/22/2017, completed 9/28/2017.</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (<i>What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

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 Incident Mgt. System - Personnel Training	Standard Level Deficiency		
<p><b>NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS</b>  <b>NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b>  <b>A. General:</b> 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.  <b>B. Training curriculum:</b> Prior to an employee or 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.  <b>C. Incident management system training curriculum requirements:</b>  <b>(1)</b> The community-based service provider shall conduct training or designate a knowledgeable</p>	<p>Based on record review, the Agency did not ensure Incident Management Training for 4 of 12 Agency Personnel.</p> <p><b>Direct Support Personnel (DSP)</b></p> <ul style="list-style-type: none"> <li>Incident Management Training (Abuse, Neglect and Exploitation) (#501, 504, 507, 509)</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →  </p>	<p>   </p>

<p>representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to:</p> <ul style="list-style-type: none"> <li>(a) an overview of the potential risk of abuse, neglect, or exploitation;</li> <li>(b) informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form;</li> <li>(c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths;</li> <li>(d) specific instructions on how to respond to abuse, neglect, or exploitation;</li> <li>(e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury.</li> </ul> <p>(2) All current employees and volunteers shall receive training within 90 days of the effective date of this rule.</p> <p>(3) All new employees and volunteers shall receive training prior to providing services to consumers.</p> <p><b>D. Training documentation:</b> 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</p>			
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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.

Tag # 1A43.1 General Events Reporting - Individual Approval	Standard Level Deficiency		
<p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy: General Events Reporting Effective 1/1/2012</b></p> <p><b>1. Purpose:</b> To report, track and analyze significant events experiences by adult participants of the DD Waiver program, which do not meet criteria for abuse, neglect or exploitation, or other “reportable incident” as defined by the Incident Management Bureau of the Division of Health Improvement, Department of Health, but which pose a risk to individuals served. Analysis of reported significant events is intended to identify emerging patterns so that preventative actions can be identified at the individual, provider agency, regional and statewide levels.</p> <p><b>II. Policy Statements:</b> A. Designated employees of each agency will enter specified information into the General Events Reporting section of the secure website operated under contract by Therap Services within 2 business days of the occurrence or knowledge by the reporting agency of any of the following defined events in which DDSD requires reporting: Chocking, Missing Person, Suicide Attempt or Threat, Restraint related to Behavior, Serious Injury including Skin Breakdown, Fall (with or without injury), Out of Home Placement and Infections...Providers shall utilize the “Significant Events Reporting System Guide” to assure that events are reported correctly for DDSD tracking purposes. At providers’ discretion additional events may be tracked within the Therap General Events Reporting which are not required by DDSD such as medication errors.</p> <p>B. General Events Reporting does not replace agency obligations to report abuse, neglect, exploitation and other reportable incidents in compliance with policies and procedures issued by the Department’s Incident Management Bureau of the Division of Health Improvement.</p>	<p>Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 1 of 10 individuals.</p> <p><b>The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and approved within 2 business days:</b></p> <p>Individual #9</p> <ul style="list-style-type: none"> <li>• General Events Report (GER) indicates on 12/7/2017 the Individual was taken to the Emergency Room due to illness (Change of Condition). GER was approved on 12/13/2017.</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →  </p>	<p>   </p>

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<b>Service Domain: Health and Welfare</b> - The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.			
<b>Tag # 1A03 CQI System - Quality Improvement / Quality Assurance Plan and Components</b>	<b>Standard Level Deficiency</b>		
<p><b>STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS</b></p> <p>d. PROVIDER shall have a Quality Management and Improvement Plan in accordance with the current MF Waiver Standards and/or the DD Waiver Standards specified by the DEPARTMENT. The Quality Management and Improvement Plan for DD Waiver Providers must describe how the PROVIDER will determine that each waiver assurance and requirement is met. The applicable assurances and requirements are: (1) level of care determination; (2) service plan; (3) qualified providers; (4) health and welfare; (5) administrative authority; and, (6) financial accountability. For each waiver assurance, this description must include:</p> <p>i. Activities or processes related to discovery, i.e., monitoring and recording the findings. 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;</p> <p>ii. The entities or individuals responsible for conducting the discovery/monitoring processes;</p> <p>iii. The types of information used to measure performance; and,</p> <p>iv. The frequency with which performance is measured.</p>	<p>Based on record review and interview, the Agency did not implement their Continuous Quality Management System as required by standard.</p> <p><b>When administrative personnel were asked how often the QA/QI committee convened, the following reported:</b></p> <ul style="list-style-type: none"> <li>• #510 stated, "We meet every 3 months."</li> </ul> <p><b>During file review the following was found in regard to QA/QI Committee Meetings:</b></p> <ul style="list-style-type: none"> <li>• QA/QI Community Meetings were not occurring on a quarterly basis. Last meeting minutes found dated 4/12/2017.</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>Chapter 1 Introduction:</b> As outlined in the quality assurance/quality improvement section in each of the service standards, all approved DDW providers are required to develop and utilize a quality assurance/quality improvement (QA/QI) plan to continually determine whether it operates in accordance with program requirements and regulations, achieves desired outcomes and identifies opportunities for improvement. CMS expects states to follow a continuous quality improvement process to monitor the implementation of the waiver assurances and methods to address identified problems in any area of non-compliance.</p> <p><b>CHAPTER 5 (CIES) 3. Agency Requirements: Quality Assurance Quality Improvement (QA/QI) Plan:</b> Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.</p> <p><b>9. Development of a QA/QI plan:</b> The QA/QI 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 QA/QI 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 QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:</p> <p>a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that</p>			
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<p>occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.</p> <ul style="list-style-type: none"> <li>b. The entities or individuals responsible for conducting the discovery/monitoring process;</li> <li>c. The types of information used to measure performance; and</li> <li>d. The frequency with which performance is measured.</li> </ul> <p><b>10. Implementing a QA/QI Committee:</b> The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy 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:</p> <ul style="list-style-type: none"> <li>a. Implementation of the ISP, including; <ul style="list-style-type: none"> <li>i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and</li> <li>ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.</li> </ul> </li> <li>b. Compliance with Caregivers Criminal History Screening requirements;</li> <li>c. Compliance with Employee Abuse Registry requirements;</li> <li>d. Compliance with DDS training requirements;</li> <li>e. Patterns in reportable incidents;</li> <li>f. Sufficiency of staff coverage;</li> <li>g. Patterns in medication errors;</li> <li>h. Action taken regarding individual grievances;</li> <li>i. Presence and completeness of required documentation; and</li> <li>j. Significant program changes.</li> </ul> <p><b>CHAPTER 6 (CCS) 3. Agency Requirements: Quality Assurance/Quality Improvement (QA/QI) Plan:</b> Community-based providers shall develop and maintain an active QA/QI plan in</p>			
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<p>order to assure the provisions of quality services.</p> <p><b>1. Development of a QA/QI plan:</b> The QA/QI 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 QA/QI 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 QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements is working. The plan shall include but is not limited to:</p> <ul style="list-style-type: none"> <li>a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.</li> <li>b. The entities or individuals responsible for conducting the discovery/monitoring process;</li> <li>c. The types of information used to measure performance; and</li> <li>d. The frequency with which performance is measured.</li> </ul> <p><b>2. Implementing a QA/QI Committee:</b> The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy 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:</p> <ul style="list-style-type: none"> <li>a. Implementation of the ISP, including:</li> </ul>			
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<p>i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and</p> <p>ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.</p> <p>b. Compliance with Caregivers Criminal History Screening requirements;</p> <p>c. Compliance with Employee Abuse Registry requirements;</p> <p>d. Compliance with DDS training requirements;</p> <p>e. Patterns in reportable incidents;</p> <p>f. Sufficiency of staff coverage;</p> <p>g. Patterns in medication errors;</p> <p>h. Action taken regarding individual grievances;</p> <p>i. Presence and completeness of required documentation; and</p> <p>j. Significant program changes.</p> <p><b>Preparation of the Report:</b> The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDS, kept on file at the agency, and made available upon request. The report will summarize the listed items above.</p> <p><b>CHAPTER 7 (CIHS) 3. Agency Requirements: Quality Assurance/Quality Improvement (QA/QI) Plan:</b> Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.</p> <p><b>1. Development of a QA/QI plan:</b> The QA/QI 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 QA/QI 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 QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation</p>			
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<p>of improvements are working. The plan shall include but is not limited to:</p> <ul style="list-style-type: none"> <li>a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.</li> <li>b. The entities or individuals responsible for conducting the discovery/monitoring process;</li> <li>c. The types of information used to measure performance; and</li> <li>d. The frequency with which performance is measured.</li> </ul> <p><b>2. Implementing a QA/QI Committee:</b> The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy 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:</p> <ul style="list-style-type: none"> <li>i. Implementation of the ISP, including:</li> <li>ii. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and</li> <li>iii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.</li> <li>b. Compliance with Caregivers Criminal History Screening requirements;</li> <li>c. Compliance with Employee Abuse Registry requirements;</li> <li>d. Compliance with DDSD training requirements;</li> <li>e. Patterns in reportable incidents;</li> <li>f. Sufficiency of staff coverage;</li> <li>g. Patterns in medication errors;</li> <li>h. Action taken regarding individual grievances;</li> <li>i. Presence and completeness of required documentation; and</li> <li>j. Significant program changes.</li> </ul>			
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<p>3. <b>Preparation of the Report:</b> The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.</p> <p><b>CHAPTER 11 (FL) 3. Agency Requirements: H. Quality Improvement/Quality Assurance (QA/QI) Program: Quality Assurance/Quality Improvement (QA/QI) Plan:</b> Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.</p> <p>1. <b>Development of a QA/QI plan:</b> The QA/QI 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 QA/QI 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 QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:</p> <ul style="list-style-type: none"> <li>a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance;</li> <li>b. The entities or individuals responsible for conducting the discovery/monitoring process;</li> <li>c. The types of information used to measure performance; and</li> </ul>			
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<p>d. The frequency with which performance is measured.</p> <p><b>2. Implementing a QA/QI Committee:</b> The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy 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:</p> <ul style="list-style-type: none"> <li>a. Implementation of the ISP, including: <ul style="list-style-type: none"> <li>i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and</li> <li>ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.</li> </ul> </li> <li>b. Compliance with Caregivers Criminal History Screening requirements;</li> <li>c. Compliance with Employee Abuse Registry requirements;</li> <li>d. Compliance with DDS training requirements;</li> <li>e. Patterns in reportable incidents;</li> <li>f. Sufficiency of staff coverage;</li> <li>g. Patterns in medication errors;</li> <li>h. Action taken regarding individual grievances;</li> <li>i. Presence and completeness of required documentation; and</li> <li>j. Significant program changes.</li> </ul> <p><b>Preparation of the Report:</b> The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDS, kept on file at the agency, and made available upon request. The report will summarize the listed items above</p> <p><b>CHAPTER 12 (SL) 3. Agency Requirements: B. Quality Assurance/Quality Improvement (QA/QI) Program: Quality Assurance/Quality Improvement (QA/QI) Plan:</b> Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.</p>			
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<p><b>1. Development of a QA/QI plan:</b> The QA/QI 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 QA/QI 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 QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements is working. The plan shall include but is not limited to:</p> <ul style="list-style-type: none"> <li>a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.</li> <li>b. The entities or individuals responsible for conducting the discovery/monitoring process;</li> <li>c. The types of information used to measure performance; and</li> <li>d. The frequency with which performance is measured.</li> </ul> <p><b>2. Implementing a QA/QI Committee:</b> The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy 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:</p> <ul style="list-style-type: none"> <li>a. Implementation of the ISP, including: <ul style="list-style-type: none"> <li>i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and</li> </ul> </li> </ul>			
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<p>ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.</p> <p>b. Compliance with Caregivers Criminal History Screening requirements;</p> <p>c. Compliance with Employee Abuse Registry requirements;</p> <p>d. Compliance with DDSD training requirements;</p> <p>e. Patterns in reportable incidents;</p> <p>f. Sufficiency of staff coverage;</p> <p>g. Patterns in medication errors;</p> <p>h. Action taken regarding individual grievances;</p> <p>i. Presence and completeness of required documentation; and</p> <p>j. Significant program changes.</p> <p><b>Preparation of the Report:</b> The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.</p> <p><b>CHAPTER 13 (IMLS) 3. Service Requirements:</b></p> <p><b>F. Quality Assurance/Quality Improvement (QA/QI) Program: Quality Assurance/Quality Improvement (QA/QI) Program:</b> Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.</p> <p><b>1. Development of a QA/QI plan:</b> The QA/QI 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 QA/QI 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 QA/QI plan must describe how the data collected will be used to improve the delivery of services</p>			
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<p>and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:</p> <ul style="list-style-type: none"> <li>a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.</li> <li>b. The entities or individuals responsible for conducting the discovery/monitoring process;</li> <li>c. The types of information used to measure performance; and</li> <li>d. The frequency with which performance is measured.</li> </ul> <p><b>2. Implementing a QA/QI Committee:</b> The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy 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:</p> <ul style="list-style-type: none"> <li>a. Implementation of the ISP, including: <ul style="list-style-type: none"> <li>i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and</li> <li>ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.</li> </ul> </li> <li>b. Compliance with Caregivers Criminal History Screening requirements;</li> <li>c. Compliance with Employee Abuse Registry requirements;</li> <li>d. Compliance with DDSD training requirements;</li> <li>e. Patterns in reportable incidents;</li> <li>f. Sufficiency of staff coverage;</li> <li>g. Patterns in medication errors;</li> <li>h. Action taken regarding individual grievances;</li> <li>i. Presence and completeness of required documentation; and</li> </ul>			
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j. Significant program changes.

**Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDS, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

**CHAPTER 14 (ANS) 3. Service Requirements:  
N. Quality Assurance/Quality Improvement**

**(QA/QI) Program: Quality Assurance/Quality Improvement (QA/QI) Plan:** Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

**1. Development of a QA/QI plan:** The QA/QI 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 QA/QI 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 QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

- a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.
- b. The entities or individuals responsible for conducting the discovery/monitoring process;

<p>c. The types of information used to measure performance; and  d. The frequency with which performance is measured.</p> <p><b>2. Implementing a QA/QI Committee:</b> The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy 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:</p> <p>a. Implementation of the ISP, including:</p> <ul style="list-style-type: none"> <li>i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and</li> <li>ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.</li> </ul> <p>b. Compliance with Caregivers Criminal History Screening requirements;</p> <p>c. Compliance with Employee Abuse Registry requirements;</p> <p>d. Compliance with DDS training requirements;</p> <p>e. Patterns in reportable incidents;</p> <p>f. Sufficiency of staff coverage;</p> <p>g. Patterns in medication errors;</p> <p>h. Action taken regarding individual grievances;</p> <p>i. Presence and completeness of required documentation; and</p> <p>j. Significant program changes.</p> <p><b>3. Preparation of the Report:</b> The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDS, kept on file at the agency, and made available upon request. The report will summarize the listed items above.</p> <p><b>NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:</b></p> <p><b>F. Quality assurance/quality improvement program for community-based service providers:</b></p>			
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<p><b>F. Quality assurance/quality improvement program for community-based service providers:</b> 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:</p> <p><b>(1)</b> community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements;</p> <p><b>(2)</b> community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and</p> <p><b>(3)</b> 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.</p>			
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Tag # 1A08.2 Healthcare Requirements	Standard Level Deficiency		
<p><b>NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b> A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.</p> <p><b>B. Documentation of test results:</b> Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.</p> <p><b>DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director’s Release: Consumer Record Requirements eff. 11/1/2012</b></p> <p><b>III. Requirement Amendments(s) or Clarifications:</b></p> <p>A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director’s release.</p> <p>H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>Chapter 5 (CIES) 3. Agency Requirements: H. Consumer Records Policy:</b> 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.</p>	<p>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 5 of 10 individuals receiving Community Inclusion.</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p><b>Community Inclusion Services / Other Services Healthcare Requirements:</b></p> <ul style="list-style-type: none"> <li>• <b>Annual Physical</b> (#7, 10)</li> <li>• <b>Annual Physical Follow-up</b> <ul style="list-style-type: none"> <li>• Individual #2 - As indicated by collateral documentation reviewed, exam was completed on 6/13/2017. Follow-up was to be completed in 6 months. No evidence of follow-up found.</li> </ul> </li> <li>• <b>Dental Exam</b> <ul style="list-style-type: none"> <li>• Individual #1 - As indicated by collateral documentation reviewed, the exam was completed on 1/14/2016. Follow-up was to be completed in 6 months. No evidence of follow-up found.</li> <li>• Individual #2 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</li> <li>• Individual #4 - As indicated by collateral documentation reviewed, the exam was completed on 6/22/2016. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found.</li> </ul> </li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

<p><b>Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p><b>Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy:</b> 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.</p> <p><b>Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy:</b> 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.</p> <p><b>Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy:</b> 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.</p> <p><b>Chapter 13 (IMLS) 2. Service Requirements:</b> 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)...</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p>	<ul style="list-style-type: none"> <li>• Individual #7 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</li> <li>• Individual #10 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</li> <li>• <b>Vision Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #2 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</li> <li>◦ Individual #7 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</li> <li>◦ Individual #10 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</li> </ul> </li> </ul>		
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**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:

- (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;

**CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING**

**G. Health Care Requirements for Community Living Services.**

(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP 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.

<p>(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.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(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.</p> <p>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.</p> <p>(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 professional for each such condition.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p>			
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<p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p>			
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Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>Chapter 5 (CIES) 3. Agency Requirements</b>  <b>H. Consumer Records Policy:</b> 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 DDS D Consumer Records Policy.</p> <p><b>Chapter 6 (CCS) 2. Service Requirements. E.</b>  The agency nurse(s) for Customized Community Supports providers must provide the following services: 1. Implementation of pertinent PCP orders; ongoing oversight and monitoring of the individual's health status and medically related supports when receiving this service;</p> <p><b>3. Agency Requirements: Consumer Records Policy:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDS D Individual Case File Matrix policy.</p> <p><b>Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy:</b> 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 DDS D Individual Case File Matrix policy.</p> <p><b>Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy:</b> 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 DDS D Individual Case File Matrix policy.</p> <p><b>I. Health Care Requirements for Family Living: 5.</b> A nurse employed or contracted by the Family</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 6 of 10 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p><b>Electronic Comprehensive Health Assessment Tool:</b></p> <ul style="list-style-type: none"> <li>• Not Found (#10)</li> </ul> <p><b>Aspiration Risk Screening Tool:</b></p> <ul style="list-style-type: none"> <li>• Not Current (#10)</li> </ul> <p><b>Semi-Annual Nursing Review of HCP/Medical Emergency Response Plans:</b></p> <ul style="list-style-type: none"> <li>• None found for 7/2016 - 1/2017 and 1/2017 - 3/2017 (ISP 7/10/2016 - 7/10/2017. ISP meeting held 4/19/2017) (#2)</li> <li>• None found for 6/2016 -12/2016 (ISP 6/30/2017 – 6/29/2018. ISP meeting held 3/27/2017) (#3)</li> <li>• None found for 6/2017 - 11/2017 (ISP 6/9/2017 - 6/8/2017) (#4)</li> </ul> <p><b>Special Health Care Needs:</b></p> <ul style="list-style-type: none"> <li>◦ <b>Nutritional Plan</b> <ul style="list-style-type: none"> <li>◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.</li> </ul> </li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (<i>What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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,</p>	<ul style="list-style-type: none"> <li>◦ Individual #9 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.</li> </ul> <p><b>Health Care Plans:</b></p> <ul style="list-style-type: none"> <li>• <b>Bowel/Bladder Function</b> <ul style="list-style-type: none"> <li>◦ Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.</li> </ul> </li> <li>• <b>Seizures</b> <ul style="list-style-type: none"> <li>◦ Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.</li> </ul> </li> <li>• <b>Health Care Plans (Unspecified)</b> <ul style="list-style-type: none"> <li>◦ Individual #10 - As indicated by the Individual Specific Training Section of the ISP the individual is required to have plans. An Electronic Comprehensive Health Assessment Tool Summary was not current to indicate required plans.</li> </ul> </li> </ul> <p><b>Medical Emergency Response Plans:</b></p> <ul style="list-style-type: none"> <li>• <b>Medical Emergency Response Plans (Unspecified)</b> <ul style="list-style-type: none"> <li>• Individual #10 - As indicated by the Individual Specific Training Section of the ISP the individual is required to have plans. An Electronic Comprehensive Health Assessment Tool Summary was not current to indicate required plans.</li> </ul> </li> </ul>		
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<p>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.</p> <p>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.</p> <p><b>Chapter 12 (SL) 3. Agency Requirements:</b>  <b>D. Consumer Records Policy:</b> 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.  <b>2. Service Requirements. L. Training and Requirements. 5. Health Related</b>  <b>Documentation:</b> For each individual receiving Living Supports- Supported Living, the provider agency must ensure and document the following:</p> <p>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;</p> <p>b. That an average of five (5) hours of documented nutritional counseling is available annually, if recommended by the IDT and clinically indicated;</p> <p>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</p>			
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<p>interactions with other healthcare providers serving the individual. All interactions must be documented whether they occur by phone or in person; and</p> <p>d. Document for each individual that:</p> <ul style="list-style-type: none"> <li>i. The individual has a Primary Care Provider (PCP);</li> <li>ii. The individual receives an annual physical examination and other examinations as specified by a PCP;</li> <li>iii. The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</li> <li>iv. The individual receives a hearing test as specified by a licensed audiologist;</li> <li>v. The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</li> <li>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).</li> <li>vii. 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.</li> <li>f. The Supported Living Provider Agency must ensure that activities conducted by agency nurses comply with the roles and responsibilities identified in these standards.</li> </ul> <p><b>Chapter 13 (IMLS) 2. Service Requirements:</b></p>			
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<p>C. Documents to be maintained in the agency administrative office, include:</p> <p>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;</p> <p>F. Annual physical exams and annual dental exams (not applicable for short term stays);</p> <p>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);</p> <p>H. Audiology/hearing exam as applicable (Not applicable for short term stays; See Medicaid policy 8.324.6 for applicable requirements);</p> <p>I. All other evaluations called for in the ISP for which the Services provider is responsible to arrange;</p> <p>J. Medical screening, tests and lab results (for short term stays, only those which occur during the period of the stay);</p> <p>L. Record of medical and dental appointments, including any treatment provided (for short term stays, only those appointments that occur during the stay);</p> <p>O. Semi-annual ISP progress reports and MERP reviews (not applicable for short term stays);</p> <p>P. Quarterly nursing summary reports (not applicable for short term stays);</p> <p><b>NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b> A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.</p> <p><b>B. Documentation of test results:</b> Results of tests and services must be documented, which</p>			
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<p>includes results of laboratory and radiology procedures or progress following therapy or treatment.</p> <p><b>Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010</b></p> <p>F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:</p> <ol style="list-style-type: none"> <li>1. A brief, simple description of the condition or illness.</li> <li>2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.</li> <li>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).</li> <li>4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.</li> <li>5. Emergency contacts with phone numbers.</li> <li>6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.</li> </ol> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual:</b> 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</p>			
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also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes.

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**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 # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency		
<p><b>7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> 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.</p> <p><b>E. Consumer and guardian orientation packet:</b> 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.</p>	<p>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 3 of 10 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found and/or incomplete:</p> <p><b>Incident Mgt. System - Parent/Guardian Training:</b></p> <ul style="list-style-type: none"> <li>• Not Found (#2, 6, 7)</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →  </p>	<p>   </p>

Tag # 1A29 Complaints / Grievances – Acknowledgement	Standard Level Deficiency		
<p><b>NMAC 7.26.3.6</b> 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].</p> <p><b>NMAC 7.26.3.13 Client Complaint Procedure Available.</b> 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]</p> <p><b>NMAC 7.26.4.13 Complaint Process: A. (2).</b> The service provider's complaint or grievance procedure shall provide, at a minimum, that: <b>(a)</b> the client is notified of the service provider's complaint or grievance procedure</p>	<p>Based on record review, the Agency did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 3 of 10 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found and/or incomplete:</p> <p><b>Complaints / Grievances Acknowledgement:</b></p> <ul style="list-style-type: none"> <li>• Not Found (#2, 6, 7)</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →  </p>	<p>   </p>

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<b>Service Domain: Medicaid Billing/Reimbursement</b> - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.			
<b>Tag # 5144 Adult Habilitation Reimbursement</b>	<b>Standard Level Deficiency</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p><b>B. Billable Units:</b> The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <p>(1) Date, start and end time of each service encounter or other billable service interval;</p> <p>(2) A description of what occurred during the encounter or service interval; and</p> <p>(3) The signature or authenticated name of staff providing the service.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 XVI. REIMBURSEMENT</b></p> <p><b>A. Billable Unit.</b> A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care.</p> <p><b>B. Billable Activities</b></p>	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 1 of 2 individuals.</p> <p>Individual #9 September 2017</p> <ul style="list-style-type: none"> <li>The Agency billed 225 units of Adult Habilitation (T2021 U1) from 9/16 - 29. Documentation received accounted for 219 units. (Note: Void and adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)</li> </ul>	<p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

<p>(1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours.</p> <p>(2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours</p> <p><b>NMAC 8.302.1.17 Effective Date 9-15-08 Record Keeping and Documentation Requirements</b> - A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.</p> <p><b>Detail Required in Records</b> - Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed, diagnosis and medical necessity of any service . . . Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.</p> <p><b>Services Billed by Units of Time</b> - Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible</p>			
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recipient and the services provided during that time unit.

**Records Retention** - A provider who receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

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

Tag # IS30 Customized Community Supports Reimbursement	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>CHAPTER 6 (CCS) 4. REIMBURSEMENT</b></p> <p><b>A. Required Records:</b> Customized Community Supports Services Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. Customized Community Supports Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.</p> <p><b>B. Billable Unit:</b></p> <ol style="list-style-type: none"> <li>1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit.</li> <li>2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit.</li> <li>3. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group assignment.</li> <li>4. The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Customized Community Supports without prior approval from DDSD.</li> <li>5. The billable unit for Individual Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit.</li> <li>6. The billable unit for Fiscal Management for Adult Education is one dollar per unit including a 10% administrative processing fee.</li> </ol>	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 1 of 7 individuals.</p> <p>Individual #8 September 2017</p> <ul style="list-style-type: none"> <li>• The Agency billed 170 units of Customized Community Supports (Group) (T2021 HB U7) from 9/1 - 15. Documentation received accounted for 132 units. <i>(Note: Void and adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)</i></li> </ul>	<p><b>Provider:</b> <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	<p>  </p>

<p>7. The billable units for Adult Nursing Services are addressed in the Adult Nursing Services Chapter.</p> <p>C. Billable Activities: All DSP activities that are:</p> <ul style="list-style-type: none"> <li>a. Provided face to face with the individual;</li> <li>b. Described in the individual's approved ISP;</li> <li>c. Provided in accordance with the Scope of Services; and</li> <li>d. Activities included in billable services, activities or situations.</li> </ul> <p>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.</p> <p>Therapy Services, Behavioral Support Consultation (BSC), and Case Management may be provided and billed for the same hours, on the same dates of service as Customized Community Supports.</p> <p><b>NMAC 8.302.1.17 Effective Date 9-15-08</b> <b>Record Keeping and Documentation Requirements</b> - A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.</p> <p><b>Detail Required in Records</b> - Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed, diagnosis and medical necessity of any service . . . Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.</p>			
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<p><b>Services Billed by Units of Time</b> - Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.</p> <p><b>Records Retention</b> - A provider who receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:</p> <ul style="list-style-type: none"> <li>(1) treatment or care of any eligible recipient</li> <li>(2) services or goods provided to any eligible recipient</li> <li>(3) amounts paid by MAD on behalf of any eligible recipient; and</li> <li>(4) any records required by MAD for the administration of Medicaid.</li> </ul>			
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Date: July 13, 2018

To: Anna Marie Blea, Executive Director  
Provider: Phame, Inc.  
Address: 2903 Agua Fria Street, Suite B  
State/Zip: Santa Fe, New Mexico 87507

E-mail Address: [amblea@phameinc.org](mailto:amblea@phameinc.org)

Region: Northeast  
Survey Date: January 5 - 12, 2018  
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012:** Customized Community Supports, Community Integrated Employment Services  
**2007:** Adult Habilitation

Survey Type: Routine

Dear Anna Marie Blea

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

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