Date:	October 29, 2014
To:	Chitra Roy, Executive Director
Provider:	Optihealth, Inc
Address:	4620 Jefferson Lane Suite A
State/Zip:	Albuquerque, New Mexico 87109
E-mail Address:	croy@optihealthnm.com
Region:	Metro
Survey Date:	September 8 - 12, 2014
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports) ***2007:*** *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)
Survey Type:	Routine
Team Leader:	Demetria Ackerman, BS, Health Care Surveyor Division of Health Improvement/Quality Management Bureau**.**
Team Members:	Nicole Brown, MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jenny Bartos, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Pareatha Madison, MS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; and Corrina Strain, RN, BSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mrs. Roy;

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:

Compliance with all Conditions of Participation.

This determination is based on your agency's compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

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

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

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

1. **Quality Management Bureau, Attention: Plan of Correction Coordinator**
   5301 Central Ave. NE Suite 400 Albuquerque, NM 87108

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

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

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

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 Anthony Fragua at 505-231-7436 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,

Demetria Ackerman, BS

Demetria Ackerman, BS
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	September 8, 2014	
Present:	**Optihealth, Inc.** Susan White, Office Manager Elizabeth Miller, Nurse **DOH/DHI/QMB** Dee Dee Ackerman, BS, Team Lead/Healthcare Surveyor Nicole Brown, MBA, Healthcare Surveyor Corrina Strain, RN, BSN, Healthcare Surveyor Pareatha Madison, MS, Healthcare Surveyor	
Exit Conference Date:	September 12, 2014	
Present:	**Optihealth, Inc.** Susan White, Office Manager Elizabeth Miller, Nurse Marcella Bahe, House Manager Albeita Lee, House Manager Jeanette Benjamin, Service Coordinator Brenda Allen, Service Coordinator Tim Dalessardo, Program Consultant Annette Webb, House Manager Vanita Green, House Manager **DOH/DHI/QMB** Dee Dee Ackerman, BS, Team Lead/Healthcare Surveyor Nicole Brown, MBA, Healthcare Surveyor Corrina Strain, RN, BSN, Healthcare Surveyor Pareatha Madison, MS, Healthcare Surveyor	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	12 2 - *Jackson* Class Members 10 - Non-*Jackson* Class Members 11 - Supported Living 2 - Adult Habilitation 7 - Customized Community Supports 1 - Customized In-Home Supports
Total Homes Visited	Number:	8
❖ Supported Living Homes Visited	Number:	8 *Note: The following Individuals share a SL residence:* ➢ #1, 7 ➢ #6, 8, 9
Persons Served Records Reviewed	Number:	12
Persons Served Interviewed	Number:	4

Persons Served Observed	Number:	8 (6 Individual chose not to participate in the interview and 2 Individuals were not available at the time of the on-site visit)
Direct Support Personnel Interviewed	Number:	18
Direct Support Personnel Records Reviewed	Number:	95
Service Coordinator Records Reviewed	Number:	2

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
    - Individual Service Plans
    - Progress on Identified Outcomes
    - 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

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 505-231-7436 or email at Anthony.Fragua@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.
6. The POC must be signed and dated by the agency director or other authorized official.

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

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

Note: **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, Anthony Fragua at 505-231-7436 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Anthony Fragua, POC Coordinator in any of the following ways:
    a. Electronically at Anthony.Fragua@state.nm.us *(preferred method)*
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Avenue NE, Suite 400, Albuquerque, NM 87108
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 DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
    - Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
    - Copies of “void and adjust” forms submitted to Xerox State Healthcare, LLC to correct all unjustified units identified and submitted for payment during your internal audit.

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

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 three (3) Service Domains.

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

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

Conditions of Participation (CoPs)

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

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

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

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

Service Domain: Level of Care

Condition of Participation:

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

Service Domain: Plan of Care

Condition of Participation:

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

Condition of Participation:

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

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

Service Domain: Qualified Providers

Condition of Participation:

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

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

Service Domain: Plan of Care

Condition of Participation:

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

Service Domain: Health, Welfare and Safety

Condition of Participation:

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

Condition of Participation:

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

QMB Determinations of Compliance

Compliance with Conditions of Participation

The QMB determination of *Compliance with Conditions of Participation* indicates that a provider is in compliance with all Conditions of Participation, (CoP). The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation in all relevant Service Domains. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) out of compliance in any of the Service Domains.

Partial-Compliance with Conditions of Participation

The QMB determination of *Partial-Compliance with Conditions of Participation* indicates that a provider is out of compliance with Conditions of Participation in one (1) to two (2) Service Domains. The agency may have one or more Condition level tags within a Service Domain. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains.

Providers receiving a 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. 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.

Attachment C

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

Introduction:

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

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: http://dhi.health.state.nm.us/qmb
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 IRC process, email the IRF Chairperson, Crystal Lopez-Beck at 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: **Optihealth, Inc. – Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)
Monitoring Type: Routine Survey
Survey Date: **September 8 - 12, 2014**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08.1 **Agency Case File - Progress Notes**	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **Chapter 5 (CIES) 3. Agency Requirements: 6. Reimbursement A. 1.** …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 6 (CCS) 3. Agency Requirements: 4. Reimbursement A. Record Requirements 1.** …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 7 (CIHS) 3. Agency Requirements: 4. Reimbursement A. 1.**…Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 11 (FL) 3. Agency Requirements: 4. Reimbursement A. 1.**…Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 6 of 12 Individuals. Review of the Agency individual case files revealed the following items were not found: **Supported Living Progress Notes/Daily Contact Logs** • Individual #9 - None found for 5/31/2014. **Customized In Home Supports Progress Notes/Daily Contact Logs** • Individual #2 - None found for 5/29/2014. **Customized Community Services Notes/Daily Contact Logs** • Individual #3 - None found for 5/6, 7, 9,12, 13, 14, 20, 21, 22, 23, 27, 28, 29, 30 and 6/2, 3, 4, 5, 6, 9, 10, 11, 16, 17, 18, 19, 24, 25, 26, 27, 2014. • Individual #5 – None found for 05/27, 28, 29, 30, 2014.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

time spent with an individual shall be kept on the written or electronic record… **Chapter 12 (SL) 3. Agency Requirements: 2. Reimbursement A. 1.** Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 13 (IMLS) 3. Agency Requirements: 4. Reimbursement A. 1.**…Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 15 (ANS) 4. Reimbursement A. 1.** …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (3) Progress notes and other service delivery documentation;	• Individual #9 – None found for 05/01, 02, 05, 06, 07, 08, 09, 12, 13, 14, 15-16, 2014. • Individual #10 – None found for 05/01-02, 05-06, 12-15, 16, 19, 20, 21, 22, 23, 27, 28, 29, 2014. • Individual #11 – None found for 06/10/2014		

Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	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 outcomes and action plan for 3 of 12 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Residential Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • None found regarding: Fun Outcome/Action Step: "….will utilize his purchases weekly for the ISP year" for 9/1 - 8, 2014. Individual #5 • None found regarding: Live Outcome/Action Step: "…will learn money denominations once a week" for 9/1 - 10, 2014. Individual #12 • According to the ISP, Fun Outcome; Action Step for "…will work on her art project daily" is to be completed 1 time per day evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/1 - 10, 2014.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Tag # LS14 / 6L14 Residential Case File	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 11 (FL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. **CHAPTER 12 (SL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. **CHAPTER 13 (IMLS) 2. Service Requirements** **B.1. Documents To Be Maintained In The Home:** a. Current Health Passport generated through the e-CHAT section of the Therap website and printed for use in the home in case of disruption in internet access; b. Personal identification; c. Current ISP with all applicable assessments, teaching and support strategies, and as applicable for the consumer, PBSP, BCIP, MERP, health care plans, CARMPs, Written Therapy Support Plans, and any other plans (e.g. PRN Psychotropic Medication Plans) as applicable; d. Dated and signed consent to release information forms as applicable; e. Current orders from health care practitioners; f. Documentation and maintenance of accurate medical history in Therap website; g. Medication Administration Records for the current month; h. Record of medical and dental appointments for the current year, or during the period of	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 6 of 11 Individuals receiving Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: • **Current Emergency and Personal Identification Information** ◦ Did not contain Pharmacy Information (#9) ◦ Did not contain Physician' s name and number (#8, 9) ◦ Did not contain health plan Information (#9) ➢ Individual Specific Training Section of ISP (formerly Addendum B) (#6) ➢ **Teaching and Support Strategies** ➢ Individual #3 - TSS not found for the following Action Steps: ◦ Live Outcome Statement: ➢ "Will be read to twice a week." ➢ "Will obtain feedback from…twice a week." ◦ Have Fun Develop Relationships/ Have Fun Statement: ➢ "Will participate in relaxation activities five times a week." ➢ "Will select a time he wants to participate in relaxation activities five times a week."	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

stay for short term stays, including any treatment provided; i. Progress notes written by DSP and nurses; j. Documentation and data collection related to ISP implementation; k. Medicaid card; l. Salud membership card or Medicare card as applicable; and m. A Do Not Resuscitate (DNR) document and/or Advanced Directives as applicable. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012** **III. Requirement Amendments(s) or Clarifications:** A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. ***Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007*** **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the	➢ Positive Behavioral Plan (#10) ➢ Positive Behavioral Crisis Plan (#10) ➢ Speech Therapy Plan (#1, 6) • Healthcare Passport (#8) ➢ **Health Care Plans** ◦ Constipation (#9) ◦ Pain (#9) ➢ **Medical Emergency Response Plans** ◦ Seizures (#10) ◦ Pain (#9)		

agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed;			

(d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
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.*			
Tag # 1A11.1 **Transportation Training**	**Standard Level Deficiency**		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy **Eff. Date:** March 1, 2007 **II. POLICY STATEMENTS:** 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: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 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) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency) **NMAC 7.9.2 F. TRANSPORTATION:** **(1)** Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training	Based on interviews, 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 2 of 95 Direct Support Personnel. **When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:** • DSP #245 stated, "A long time ago when I was working with the other agency." • DSP #270 stated, "I have not received defensive driving yet."	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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

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

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

Tag # 1A22 Agency Personnel Competency	Standard Level Deficiency		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 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. **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-	Based on interview, the Agency did not ensure training competencies were met for 3 of 18 Direct Support Personnel. **When DSP were asked if the individual had a Positive Behavioral Crisis Plan and if so, what the plan covered, the following was reported:** • DSP #211 stated, "I believe there is one in there. I can't really tell you." According to the agency file, the individual has Positive Behavioral Crisis Plan. (Individual #8) **When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #287 stated, "I know she has a SLP, but I don't know if she has a plan." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #4) **When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #211 stated," I believe so, but I can't remember." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #8) **When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:**	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training. **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. B. Individual specific training must be arranged and conducted, including training on the	• DSP #211 stated, "He does have them but I can't remember." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Status of Care/ Hygiene, Aspiration, Falls and Respiratory. (Individual #8) • DSP #274 stated, "No not that I know of." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index, Aspiration, Seizures, Constipation, Respiratory and Falls. (Individual #4) **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:** • DSP # 211 stated, "He does have them but I can't remember." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Aspiration, Status of Care/Hygiene, Respiratory and Falls.(Individual #8) **When DSP were asked what the individual's Diagnosis were, the following was reported:** • DSP #211 stated, "Honestly I would not know. He has been delusional." According to the individuals Electronic Comprehensive Health Assessment Tool he is diagnosed with Bipolar I Disorder, Cognitive Disorder NOS, Schizoaffective Disorder, Mild Intellectual Disabilities, Allergic Rhinitis, Apnea, Sleep Disturbance, Bile Reflux Gastritis, Cellulitis of Leg, Constipation, DVT-NOS, Embolism, Pulmonary, Hypertension unspecified,		

Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc), information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc), and information	Hypotension unspecified, Unspecified vitamin deficiency, Urinary Incontinence. Staff did not discuss the listed diagnosis. (Individual #8)		

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 # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency		
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** 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. **C. Incident management system training curriculum requirements:** **(1)** The community-based service provider shall conduct training or designate a	Based on record review the Agency did not ensure Incident Management Training for 3 of 97 Agency Personnel. **Direct Support Personnel (DSP):** • Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (DSP# 202, 272) **When Direct Support Personnel were asked what State Agency must be contacted when there is suspected Abuse, Neglect and Misappropriation of Consumers' Property, the following was reported:** • DSP #217 stated, "APS." Staff was not able to identify the State Agency as DHI.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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

shall subject the community-based service provider to the penalties provided for in this rule. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007** **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Health and Welfare – *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.*			
Tag # 1A09 **Medication Delivery** **Routine Medication Administration**	**Standard Level Deficiency**		
NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the	Medication Administration Records (MAR) were reviewed for the months of August and September 2014. Based on record review, 3 of 12 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #4 September 2014 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Quetiapine Furnarate 300mg (1 time daily) – Blank 9/8 (8 PM) • Quetiapine Furnarate 100mg (1 time daily) – Blank 9/8 (Noon) • Niacin 500mg 3 tablets (1 time daily) - Blank 9/8 (8PM) • Calcium Antacid 500mg (2 times daily) - Blank 9/8 (8PM) • Valproic Acid 250mg/5ml (3 times daily) - Blank 9/8 (2PM; 8PM), 9/9 (2PM) • Clonidine HCL 0.1mg (2 times daily) - Blank 9/9 (3PM)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 1. Scope of Service B. Self Employment 8.** Providing assistance with medication delivery as outlined in the ISP; **C. Individual Community Integrated Employment 3.** Providing assistance with medication delivery as outlined in the ISP; **D. Group Community Integrated Employment 4.** Providing assistance with medication delivery as outlined in the ISP; and **B. Community Integrated Employment Agency Staffing Requirements: o.** Comply with DDSD Medication Assessment and Delivery Policy and Procedures; **CHAPTER 6 (CCS) 1. Scope of Services A. Individualized Customized Community Supports 19.** Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. **C. Small Group Customized Community Supports 19.** Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. **D. Group Customized Community Supports 19.** Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. **CHAPTER 12 (SL) 2. Service Requirements L. Training and Requirements: 3. Medication** Delivery: Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD	Individual #5 September 2014 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries • Vitamin B Complex (1 time daily) - Blank 9/10 (8 AM) • Valporic Acid 250mg/5ml (3 times daily) - Blank 9/2 - 05 and 9/8 - 10 (2 PM) Individual #12 September 2014 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Omeprazole 20mg Medication Administration Records did not contain the frequency for which the medication is prescribed: • Omeprazole 20mg		

Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations. a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations; b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. c. The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial			

used to document administered or assisted delivery of each dose; and d. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administrating the medication, signs, and symptoms of adverse events and interactions with other medications. **CHAPTER 13 (IMLS) 2. Service Requirements.** **B.** There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of			

the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;			

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Standard Level Deficiency		
NMAC 16.19.11.8 MINIMUM STANDARDS: **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period.	Medication Administration Records (MAR) were reviewed for the months of August and September 2014. Based on record review, 1 of 12 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #9 September 2014 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Ibuprofen (PRN) Medication Administration Records did not contain the strength of the medication which is to be given: • Ibuprofen (PRN)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006 **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's			

diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:** **Medication Assessment and Delivery** **Procedure Eff Date: November 1, 2006** C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on			

the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.). Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 11 (FL) 1 SCOPE OF SERVICES** **A. Living Supports- Family Living Services:** The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT): **19.** Assisting in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and **I. Healthcare Requirements for Family Living.** **3. B.** Adult Nursing Services for medication oversight are required for all surrogate Lining Supports- Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication. **6.** Support Living- Family Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations. a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated			

individuals must be licensed by the Board of Pharmacy, per current regulations; b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. c. The Family Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and d. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications.			

e. Medication Oversight is optional if the individual resides with their biological family (by affinity or consanguinity). If Medication Oversight is not selected as an Ongoing Nursing Service, all elements of medication administration and oversight are the sole responsibility of the individual and their biological family. Therefore, a monthly medication administration record (MAR) is not required unless the family requests it and continually communicates all medication changes to the provider agency in a timely manner to insure accuracy of the MAR. i. The family must communicate at least annually and as needed for significant change of condition with the agency nurse regarding the current medications and the individual's response to medications for purpose of accurately completing required nursing assessments. ii. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not deliver medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a Certified Medication Aide (CMA). Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements. iii. If the substitute care provider is a surrogate (not related by affinity or consanguinity) Medication Oversight must be selected and provided. **CHAPTER 12 (SL) 2. Service Requirements L. Training and Requirements: 3.** Medication Delivery: Supported Living Provider Agencies must have written policies and procedures			

regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations. e. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations; f. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of			

effectiveness of PRN medication administered. g. The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and h. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administrating the medication, signs, and symptoms of adverse events and interactions with other medications. **CHAPTER 13 (IMLS) 2. Service Requirements. B.** There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.			

E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to			

document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;			

Tag # 1A11 Transportation Policy and Procedure	Standard Level Deficiency		
STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 2. APPLICABLE LAWS: This Provider Agreement shall be governed by the laws of the State of New Mexico. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy:** Training Requirements for Direct Service Agency Staff Policy **Eff Date:** March 1, 2007 **II. POLICY STATEMENTS:** 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: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 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) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)	Based on record review the Agency did not have written policies and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals. Review of Agency's policies and procedures indicated the following elements were not found: (5) Emergency Plans, including vehicle evacuation techniques (7) Accident Procedures	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) I. Scope of Services A. Job Development: 11.** Arranging or providing transportation during Job Development activities; and **B. Self Employment**: 7. Arranging or providing transportation during Job Development activities; and **C. Intergrated Employment Services: 2.** Arranging or providing transportation or supporting public transportation during Individual Community Integrated Employment Services; **Intergrated Employment Services: D. 3.** Arranging or providing transportation or supporting public transportation during Group Community Integrated Employment Services; **CHAPTER 6 (CCS) I. Scope of Service A. Individualized Customized Community Supports** 17. Providing transportation or assisting with transportation arrangements for participating in Customized Community Supports; **C. Small Group Customized Community Supports** 17. Providing or assisting with transportation during provision of Customized Community Supports; **D. Group Customized Community Supports** 17. Providing or assisting with transportation during provision of Customized Community Supports; **CHAPTER 11 (FL) 2. Service Requirements: I. Healthcare Requirements for Family Living: 10.** Family Living provider agencies must have a written policy and procedures regarding the safe transportation of individuals in the community, and comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and			

procedures must address at least the following topics: **a.** Drivers' requirements; **b.** Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions; **c.** Vehicle maintenance and safety inspections; **d.** DSP training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures; **e.** Emergency Plans, including vehicle evacuation techniques; **f.** Accident Procedures; and **g.** Written documentation of vehicle maintenance, safety inspections, and staffing training. **CHAPTER 12 (SL) 2. Service Requirements: L. Training and Requirements 7. Transportation:** Supported Living provider agencies must have a written policy and procedures regarding the safe transportation of individuals in the community, and comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety." The policy and procedures must address at least the following topics: a. Drivers' requirements; b. Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions; c. Vehicle maintenance and safety inspections; d. DSP training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures; e. Emergency Plans, including vehicle evacuation techniques;			

f. Accident Procedures; and g. Written documentation of vehicle maintenance, safety inspections, and staffing training. **CHAPTER 13 (IMLS) 2. Service Requirements: N.** Services provider agencies must develop and implement policies and procedures regarding the safe transportation of individuals in the community which comply with New Mexico regulations governing operation of motor vehicles to transport individuals and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and procedures must address at least the following: 1. Documented evidence of driver requirements; 2. Individual safety including locations for boarding and disembarking passengers, and appropriate response to hazardous weather and other adverse driving conditions, including securing all equipment and supplies needed to assure health and safety during transport; 3. Vehicle maintenance and safety inspections; 4. Documented evidence of driver training regarding safe operation of the vehicle, assisting passengers, and safe lifting procedures; 5. Emergency plans including vehicle evacuation techniques; and 6. Accident procedures.			

Tag # 1A27 Incident Mgt. Late and Failure to Report	Standard Level Deficiency		
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **A. Duty to report:** **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** **(1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of	Based on the Incident Management Bureau's Late and Failure Reports, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 9 of 17 individuals. Individual #9 • Incident date 2/22/2014. Allegation was Emergency Services/Law Enforcement Involvement. Incident report was received on 2/27/2014. IMB issued a Late Reporting for Emergency Services/Law Enforcement Involvement. • Incident date 5/27/2014. Allegation was Law Enforcement Involvement. Incident report was received on 5/29/2014. IMB issued a Late Reporting for Law Enforcement Involvement. Individual #10 • Incident date 1/9/2014. Allegation was Neglect. Incident report was received on 3/20/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." Individual #11 • Incident date 12/11/2013. Allegation was Neglect. Incident report was received on 12/11/2013. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." Individual #12 • Incident date 6/17/2014. Allegation was Abuse. Incident report was received on	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. **(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form. **(3) Limited provider investigation:** No investigation beyond that necessary in order to	6/18/2014. Failure to Report. IMB Late and Failure Report indicated incident of Abuse was "Confirmed." Individual #13 • Incident date 4/14/2014. Allegation was Neglect. Incident report was received on 4/15/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." Individual #14 • Incident date 6/26/2014. Allegation was Neglect. Incident report was received on 6/30/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed." Individual #15 • Incident date 11/27/2013. Allegation was Abuse. Incident report was received on 12/2/2013. Failure to Report. IMB Late and Failure Report indicated incident of Abuse was "Unconfirmed." • Incident date 12/16/2013. Allegation was Abuse. Incident report was received on 12/17/2013. Failure to Report. IMB Late and Failure Report indicated incident of Abuse was "Unconfirmed." Individual #16 • Incident date 11/7/2013. Allegation was Neglect. Incident report was received on 11/12/2013. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." Individual #17 • Incident date 4/14/2014. Allegation was Neglect. Incident report was received on 4/15/2014. Failure to Report. IMB Late and		

be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation. **(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall: **(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable; **(b)** be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and **(c)** provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057. **(5) Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident. **(6) Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the	Failure Report indicated incident of Neglect was "Unconfirmed."		

alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative. **(7) Case manager or consultant notification by community-based service providers:** The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant. **(8) Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation			

Tag # 1A31 Client Rights/Human Rights	Standard Level Deficiency		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division** **Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003**	Based on record review, the Agency did not ensure the rights of Individuals was not restricted or limited for 1 of 12 Individuals. A review of Agency Individual files found no documentation of Positive Behavior Plans and/or Positive Behavior Crisis Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (#11) No current Human Rights Approval was found for the following: • Physical Restraint; Last Review was dated 4/2014. (Individual #11)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

IV. POLICY STATEMENT - Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans. Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies: • Aversive Intervention Prohibitions • Psychotropic Medications Use • Behavioral Support Service Provision. A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up. **A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS** Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval. 2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly. 3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan.			

Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: **Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** **B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).			

Tag # LS13 / 6L13 Community Living Healthcare Reqts.	Standard Level Deficiency		
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy:** All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING**	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 2 of 11 individuals receiving Community Living Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: • ***Dental Exam*** ◦ Individual #9 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • ***Vision Exam*** ◦ Individual #8 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.			

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

Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 11 (FL) Living Supports – Family Living Agency Requirements G. Residence Requirements for Living Supports- Family Living Services:** 1.Family Living Services providers must assure that each individual's residence is maintained to be clean, safe and comfortable and accommodates the individuals' daily living, social and leisure activities. In addition the residence must: a. Maintain basic utilities, i.e., gas, power, water and telephone; b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; c. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system; d. Have a general-purpose first aid kit; e. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; f. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year; g. Have accessible written procedures for the safe storage of all medications with	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 6 of 8 Supported Living residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence (#6, 8, 9) • Water temperature in home does not exceed safe temperature (110^0 F) ➢ Water temperature in home measured 140^0 F (#1, 7) ➢ Water temperature in home measured 128^0 F (#3) ➢ Water temperature in home measured 133.2^0 F (#4) ➢ Water temperature in home measured 143^0 F (#10) ➢ Water temperature in home measured 143^0 F (#11) • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#4)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and h. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. **CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports- Supported Living Services:** 1. Supported Living Provider Agencies must assure that each individual's residence is maintained to be clean, safe, and comfortable and accommodates the individual's daily living, social, and leisure activities. In addition the residence must: a. Maintain basic utilities, i.e., gas, power, water, and telephone; b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; c. Ensure water temperature in home does not exceed safe temperature (110^0 F) ; d. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system;	• Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#4) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#4) *Note: The following Individuals share a residence:* ➢ #6, 8, 9 ➢ #1, 7		

e. Have a general-purpose First Aid kit; f. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; g. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills must occur at least once a year during each shift; h. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and i. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. **CHAPTER 13 (IMLS) 2. Service Requirements R. Staff Qualifications: 3. Supervisor Qualifications And Requirements:** S Each residence shall include operable safety equipment, including but not limited to, an operable smoke detector or sprinkler system, a carbon monoxide detector if any natural gas appliance or heating is used, fire extinguisher, general purpose first aid kit, written procedures for emergency evacuation due to fire or other emergency and documentation of evacuation drills occurring			

at least annually during each shift, phone number for poison control within line of site of the telephone, basic utilities, general household appliances, kitchen and dining utensils, adequate food and drink for three meals per day, proper food storage, and cleaning supplies. T Each residence shall have a blood borne pathogens kit as applicable to the residents' health status, personal protection equipment, and any ordered or required medical supplies shall also be available in the home. U If not medically contraindicated, and with mutual consent, up to two (2) individuals may share a single bedroom. Each individual shall have their own bed. All bedrooms shall have doors that may be closed for privacy. Individuals have the right to decorate their bedroom in a style of their choosing consistent with safe and sanitary living conditions. V For residences with more than two (2) residents, there shall be at least two (2) bathrooms. Toilets, tubs/showers used by the individuals shall provide for privacy and be designed or adapted for the safe provision of personal care. Water temperature shall be maintained at a safe level to prevent injury and ensure comfort and shall not exceed one hundred ten (110) degrees. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services**			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag # 5I44 **Adult Habilitation Reimbursement**	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** 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. **B. Billable Units:** 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: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services	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. Individual #12 May 20014 • The Agency billed 24 units of Adult Habilitation (T2021 U1) on 05/26/2014. Documentation did not contain the required elements on 5/26/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No description of services provided. Progress note simply stated “Holiday”.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care. **B. Billable Activities** (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. (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			

Tag # IS30 Customized Community Supports Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 6 (CCS) 4. REIMBURSEMENT A. Required Records:** All Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, nature of services, and length of a session of service billed. 1. The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit billed, the record shall contain the following: a. Date, start and end time of each service encounter or other billable service interval; b. A description of what occurred during the encounter or service interval; and c. The signature or authenticated name of staff providing the service. B. **Billable Unit:** 1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit. 2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 7 of 7 individuals. Individual #3 May 2014 • The Agency billed 18 units of Customized Community Supports (Individual) (H2021 HB U1) on 5/6/2014. Documentation did not contain the required elements on 5/6/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 18 units of Customized Community Supports (Individual) (H2021 HB U1) on 5/7/2014. Documentation did not contain the required elements on 5/7/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/09/2014. Documentation did not contain the required elements on 05/09/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/12/2014. Documentation did not contain the required elements on	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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. 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. 5. The billable unit for Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit. (There is a separate rate established for individuals who require one-to-one (1:1) support either in the community or in a group day setting due to behavioral challenges (NM DDW group G). 6. The billable unit for Fiscal Management for Adult Education is dollars charged for each class including a 10% administrative processing fee. C. **Billable Activities:** 1. All DSP activities that are: a. Provided face to face with the individual; b. Described in the individual's approved ISP; c. Provided in accordance with the Scope of Services; and d. Activities included in billable services, activities or situations. 2. Purchase of tuition, fees, and/or related materials associated with adult education opportunities as related to the ISP Action	05/12/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 12 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/13/2014. Documentation did not contain the required elements on 05/13/2014. Documentation received accounted for 0 units. One or more required elements was not met:: ➢ No documentation found. • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/14/2014. Documentation did not contain the required elements on 05/14/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB U1) on 5/15/2014. Documentation received accounted for 10 units. • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB U1) on 5/16/2014. Documentation received accounted for 3 units. • The Agency billed 10 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/20/2014. Documentation did not contain the required elements on 05/20/2014. Documentation received accounted for 0 units. One or more required elements was not met:: ➢ No documentation found.		

Plan and Outcomes, not to exceed $550 including administrative processing fee. 3. Customized Community Supports can be included in ISP and budget with any other services. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.	• The Agency billed 13 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/21/2014. Documentation did not contain the required elements on 05/21/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 14 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/22/2014. Documentation did not contain the required elements on 05/22/2014. Documentation received accounted for 0 units. One or more required elements was not met:: ➢ No documentation found. • The Agency billed 14 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/23/2014. Documentation did not contain the required elements on 05/23/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 12 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/27/2014. Documentation did not contain the required elements on 05/27/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 18 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/28/2014. Documentation did not contain the required elements on 05/28/2014. Documentation received		

	accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 14 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/29/2014. Documentation did not contain the required elements on 05/29/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 14 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/30/2014. Documentation did not contain the required elements on 05/30/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. June 2014 The Agency billed 120 units of Customized Community Supports (group) (T2021 HB U8) from 06/02/20104 through 6/06/2014. Documentation received accounted for 106 units. • The Agency billed 7 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/02/2014. Documentation did not contain the required elements on 06/02/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 16 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/03/2014. Documentation did not contain the required elements on		

	06/03/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 15 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/04/2014. Documentation did not contain the required elements on 06/04/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 12 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/05/2014. Documentation did not contain the required elements on 06/05/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 14 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/06/2014. Documentation did not contain the required elements on 06/06/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 12 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/09/2014. Documentation did not contain the required elements on 06/09/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found.		

	• The Agency billed 120 units of Customized Community Supports (group) (T2021 HB U8) from 06/09/20104 through 6/13/2014. Documentation received accounted for 96 units. • The Agency billed 18 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/10/2014. Documentation did not contain the required elements on 06/10/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 10 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/11/2014. Documentation did not contain the required elements on 06/11/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 14 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/16/2014. Documentation did not contain the required elements on 06/16/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 120 units of Customized Community Supports (group) (T2021 HB U8) from 06/16/20104 through 6/20/2014. Documentation received accounted for 84 units. • The Agency billed 10 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/17/2014. Documentation did		

	not contain the required elements on 06/17/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 23 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/18/2014. Documentation did not contain the required elements on 06/18/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 4 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/19/2014. Documentation did not contain the required elements on 06/19/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 15 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/24/2014. Documentation did not contain the required elements on 06/24/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 17 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/25/2014. Documentation did not contain the required elements on 06/25/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found.		

	• The Agency billed 24 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/26/2014. Documentation did not contain the required elements on 06/26/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 18 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/27/2014. Documentation did not contain the required elements on 06/27/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 12 units of Customized Community Supports (Individual) (H2021 HB U1) on 06/30/2014. Documentation did not contain the required elements on 06/30/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. Individual #5 May 2014 • The Agency billed 24 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/27/2014. Documentation did not contain the required elements on 05/27/2014. Documentation received accounted for 0 units. One or more required elements was not met:: ➢ No documentation found. • The Agency billed 24 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/28/2014. Documentation did not contain the required elements on		

	05/28/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 24 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/29/2014. Documentation did not contain the required elements on 05/29/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 24 units of Customized Community Supports (Individual) (H2021 HB U1) on 05/30/2014. Documentation did not contain the required elements on 05/30/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. Individual #6 May 2014 • The Agency billed 24 units of Customized Community Supports (group) (T2021 HB U8) on 05/06/2014. Documentation did not contain the required elements on 05/06/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No description of services provided. Progress note stated "Not Scheduled Today". • The Agency billed 24 units of Customized Community Supports (group) (T2021 HB U8) on 5/9/2014. Documentation did not contain the required elements on 5/9/2014. Documentation received accounted for 0		

	units. One or more required elements was not met: ➢ Date of each service encounter or other billable service interval. Individual #7 May 2014 • The Agency billed 70 units of Customized Community Supports (group) (T2021 HB U8) from 5/12/2014 to 5/16/2014. Documentation received accounted for 60 units. Individual #9 May 2014 • The Agency billed 16 units of Customized Community Supports (individual) (H2021 HB U1) on 5/01/2014. Documentation did not contain the required elements on 5/01/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 8 units of Customized Community Supports (individual) (H2021 HB U1) on 5/02/2014. Documentation did not contain the required elements on 5/02/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 10 units of Customized Community Supports (individual) (H2021 HB U1) on 5/05/2014. Documentation did not contain the required elements on 5/05/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found.		

	• The Agency billed 14 units of Customized Community Supports (individual) (H2021 HB U1) on 5/06/2014. Documentation did not contain the required elements on 5/06/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 10 units of Customized Community Supports (individual) (H2021 HB U1) on 5/07/2014. Documentation did not contain the required elements on 5/07/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 12 units of Customized Community Supports (individual) (H2021 HB U1) on 5/08/2014. Documentation did not contain the required elements on 5/08/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 4 units of Customized Community Supports (individual) (H2021 HB U1) on 5096/2014. Documentation did not contain the required elements on 5/09/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 10 units of Customized Community Supports (individual) (H2021 HB U1) on 5/12/2014. Documentation did not contain the required elements on 5/12/2014. Documentation received		

	accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 6 units of Customized Community Supports (individual) (H2021 HB U1) on 5/13/2014. Documentation did not contain the required elements on 5/13/2014. Documentation received accounted for 0 units. One or more required elements was not met:: ➢ No documentation found. • The Agency billed 4 units of Customized Community Supports (individual) (H2021 HB U1) on 5/14/2014. Documentation did not contain the required elements on 5/14/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 20 units of Customized Community Supports (individual) (H2021 HB U1) from 5/15/2014 through 05/16/2014. Documentation did not contain the required elements from 5/15/2014 through 05/16/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. Individual #10 May 2014 • The Agency billed 24 units of Customized Community Supports (group) (T2021 HB U7) from 5/01/2014 through 05/02/2014. Documentation did not contain the required elements on 5/01/2014 through 05/02/2014. Documentation received		

	accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 24 units of Customized Community Supports (group) (T2021 HB U7) from 5/05/2014 through 05/06/2014. Documentation did not contain the required elements on 5/05/2014 through 05/06/20014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 24 units of Customized Community Supports (individual) (H2021 HB U1) from 5/5/2014 through 05/06/2014. Documentation did not contain the required elements on 5/5/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ Start and end time of each service encounter or other billable service interval. • The Agency billed 12 units of Customized Community Supports (group) (T2021 HB U7) on 5/09/2014. Documentation did not contain the required elements on 5/09/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 48 units of Customized Community Supports (group) (T2021 HB U7) from 5/12/2014 through 05/15/2014. Documentation did not contain the required elements on 5/12/2014 through 05/15/20014. Documentation received accounted for 0 units. One or more required elements was not met:		

	➢ No documentation found. • The Agency billed 14 units of Customized Community Supports (group) (T2021 HB U7) on 05/16/2014. Documentation did not contain the required elements on 05/16/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 14 units of Customized Community Supports (group) (T2021 HB U7) on 05/19/2014. Documentation did not contain the required elements on 05/19/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 14 units of Customized Community Supports (individual) (H2021 HB U1) on 5/19/2014. Documentation received accounted for 7 units. • The Agency billed 18 units of Customized Community Supports (group) (T2021 HB U7) on 05/20/2014. Documentation did not contain the required elements on 05/20/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 18 units of Customized Community Supports (individual) (H2021 HB U1) on 5/20/2014. Documentation received accounted for 6 units. • The Agency billed 14 units of Customized Community Supports (group) (T2021 HB U7) on 05/21/2014. Documentation did not		

	contain the required elements on 05/21/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 12 units of Customized Community Supports (group) (T2021 HB U7) on 05/22/2014. Documentation did not contain the required elements on 05/22/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 14 units of Customized Community Supports (group) (T2021 HB U7) on 05/23/2014. Documentation did not contain the required elements on 05/23/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 14 units of Customized Community Supports (individual) (H2021 HB U1) on 5/23/2014. Documentation received accounted for 12 units. • The Agency billed 19.75 units of Customized Community Supports (group) (T2021 HB U7) on 05/27/2014. Documentation did not contain the required elements on 05/27/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 19.75 units of Customized Community Supports (individual) (H2021 HB U1) on 5/27/2014.		

	Documentation received accounted for 18 units. • The Agency billed 12 units of Customized Community Supports (group) (T2021 HB U7) on 05/28/2014 through 05/29/2014. Documentation did not contain the required elements on 05/28/2014 through 05/29/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 12 units of Customized Community Supports (group) (T2021 HB U7) on 05/30/2014. Documentation did not contain the required elements on 05/30/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. June 2014 • The Agency billed 14 units of Customized Community Supports (individual) (H2021 HB U1) on 06/02/2014. Documentation did not contain the required elements on 06/02/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found. • The Agency billed 22 units of Customized Community Supports (individual) (H2021 HB U1) on 6/16/2014. Documentation received accounted for 12 units. • The Agency billed 32 units of Customized Community Supports (individual) (H2021 HB U1) from 06/26/2014 through 6/27/2014.		

	Documentation received accounted for 24 units. Individual #11 June 2014 • The Agency billed 24 units of Customized Community Supports (group) (T2021 HB U8) on 06/10/2014. Documentation did not contain the required elements on 06/10/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found.		

Tag # LS26 / 6L26 Supported Living Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 12 (SL) 2. REIMBURSEMENT** **A.** Supported Living Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity, and clinical necessity of services furnished to individuals who are currently receiving services. The Supported Living 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. 1. The documentation of the billable time spent with an individual must be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit billed, the record must contain the following: a. Date, start and end time of each service encounter or other billable service interval; b. A description of what occurred during the encounter or service interval; c. The signature or authenticated name of staff providing the service; d. The rate for Supported Living is based on categories associated with each individual's NM DDW Group; and e. A non-ambulatory stipend is available for those who meet assessed need requirement. **B. Billable Units:** 1. The billable unit for Supported Living is based on a daily rate. A day is determined	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 1 of 11 individuals. Individual #9 May 2014 • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 5/27/2014. Documentation did not contain the required elements on 5/27/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No description of services provided. Progress notes stated the individual was "in the hospital". • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 5/31/2014. Documentation did not contain the required elements on 5/31/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

based on whether the individual was residing in the home at midnight. 2. The maximum allowable billable units cannot exceed three hundred forty (340) calendar days per ISP year or one hundred seventy (170) calendar days per six (6) months. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** 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. **B. Billable Units:** 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: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services			

provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES** A. **Reimbursement** for Supported Living Services (1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year. (2) **Billable Activities** (a) Direct care provided to an individual in the residence any portion of the day. (b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community. (c) Any activities in which direct support staff provides in accordance with the Scope of Services. (3) Non-Billable Activities (a) The Supported Living Services provider shall not bill DD Waiver for Room and Board. (b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services. (c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.			

Tag # IH32 Customized In-Home Supports Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 7 (CIHS) 4. REIMBURSEMENT. A.** All Provider Agencies must 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 individual's name, date, time, Provider Agency name, nature of services and length of a session of service billed. 1. The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit billed, the record shall contain the following: a. Date, start and end time of each service encounter or other billable service interval; b. A description of what occurred during the encounter or service interval; and c. The signature or authenticated name of staff providing the service. 2. Customized In-Home Supports has two different rates which are based on the individual's living condition (i.e., Living with Natural Supports or Living Independently). The maximum allowable billable hours cannot exceed the budget allocation in the associated service packages.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized In-Home Supports Reimbursement for 1 of 1 individuals. Individual #2 • The Agency billed 2 units of Customized In-Home Supports (S5125 HB UA) on 5/29/2014. Documentation received accounted for 0 units. One or more required elements was not met: ➢ No documentation found.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

B. Billable Units: The billable unit for Customized In-Home Support is based on a fifteen (15) minute unit. **C. Billable Activities:** 1. Direct care provided to an individual in the individual's residence, consistent with the Scope of Services, any portion of the day. 2. Direct support provided to an individual consistent with the Scope of Services by Customized In-Home Supports direct support personnel in community locations other than the individual's residence.			

Date: December 23, 2014

To: Chitra Roy, Executive Director
Provider: Optihealth, Inc
Address: 4620 Jefferson Lane Suite A
State/Zip: Albuquerque, New Mexico 87109

E-mail Address: croy@optihealthnm.com

Region: Metro
Survey Date: September 8 - 12, 2014
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)
Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Mrs. Roy,

Your request for a Reconsideration of Findings was received on November 14, 2014. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A08.1
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the documentation provided, the following modifications will be made to the original finding. The remaining citations noted in this tag were not disputed.

- Supported Living Progress Notes/Daily Contact Logs
  - Individual #9
    - May 2014
      - Original Finding – No documentation found for 05/31/2014.
        - Finding for the above date will be removed as documentation was provided.
- Customized Community Services (CCS) Notes/Daily Contact Logs
  - Individual #3
    - May 2014
      - Original Finding - No documentation found for CCS (Individual) (H2021 HB U1) on 05/06, 07, 09, 12, 13, 14, 20, 21, 22, 23, 27, 28, 29 and 30, 2014.

        - Findings for 05/06, 09, 12, 13, 14, 20, 21, 22 and 23 will be upheld. CCS notes were provided, however, unable to differentiate between CCS group services (T2021 HB U8) and CCS Individual services (H2021 HB U1). Only one note was provided which presumably documented both services, however, progress note documentation must be clear to differentiate between services and include the time in/time out, description of services and staff signature for each unit billed.
        - Finding for 05/07/2014 will be removed. Per remittance forms, agency did not bill services for CCS Individual H2021 HB U1 on this day.
        - Findings for 05/27, 28, 29, and 30 will be removed as documentation was provided for these days.
    - June 2014
        - Original Finding - No documentation found for CCS Services on 06/02, 03, 04, 05, 06, 09, 10, 11, 16, 17, 18, 19, 24, 25, 26 and 27, 2014
            - Findings for 06/02, 03, 04, 05, 06, 09, 10, 11 and 18, 2014 will be upheld. CCS notes were provided, however, unable to differentiate between CCS group services (T2021 HB U8) and CCS Individual services (H2021 HB U1). Only one note was provided which presumably documented both services, however, progress note documentation must be clear to differentiate between services and include the time in/time out, description of services and staff signature for each unit billed.
            - Findings on 06/16, 17 and 19, 2014 will be removed as documentation was provided for these days.
            - Findings on 06/24, 25, 26 and 27, 2014 will be upheld. No documentation for CCS (Individual) (H2021 HB U1) provided. Only documentation for CCS (group) (T2021 HB U8) provided.
- Individual #5
    - May 2014
        - Original Finding - No documentation found for CCS Services 05/27, 28, 29 and 30, 2014.
            - Findings for 05/27, 28, 29 and 30, 2014 will be upheld. A final version of the Document Request Form which lists the above progress notes as missing was provided to the agency on 09/12/2014. Documentation was not presented to the survey team by the time of exit.
- Individual #9
    - May 2014
        - Original Finding - No documentation for CCS Services on 05/01, 02, 05, 06, 07, 08, 09, 12, 13, 14 and 15-16, 2014.
            - Findings for all the above dates will be removed as documentation was provided.

- Individual #10
  - May 2014
    - Original Finding - No documentation for CCS services on 05/01-02, 05-06, 12-15, 16, 19, 20, 21, 22, 23, 27, 28 and 29, 2014.
      - Findings for all the above dates will be removed as documentation was provided.
- Individual #11
  - June 2014
    - Original Finding - No documentation for CCS services on 06/10/2014.
      - Finding for the above date will be removed as documentation was provided.

Regarding Tag # 1A11.1
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Although training certificates were provided for Direct Support Personnel (DSP) #245 and 270, this was a competency based question and both DSP #245 and 270 stated they had not received transportation training through the agency.

Regarding Tag #1A22
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Documentation provided verified that DSP #274 does not work with Individual #4. The finding for this DSP in regards to Individual #4 will be removed. The remaining citations noted in this tag were not disputed.

Regarding Tag # 1A28.1
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Documentation provided verifies that DSP #272 had received training. The remaining citations noted in this tag were not disputed.

Regarding Tag #1A27
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. No evidence was provided to show that the determination of late or failure was removed by the Incident Management Bureau.

Regarding Tag #5I44
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Documentation provided still does not provided a description of services for 05/26/2014.

Regarding Tag #IS30

Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. The modifications and removal of billing deficiencies are as follows:

- Individual #3
  - May 2014
    - Original Finding - No documentation found for CCS Individual (H2021 HB U1) on 05/06, 07, 09, 12, 13, 14, 20, 21, 22 and 23, 2014.
      - Findings for the above dates were upheld. CCS notes provided, however, unable to differentiate between CCS group services (T2021 HB U8) and CCS Individual services (H2021 HB U1). Only one note was provided which presumably documented both services, however, progress note documentation must be clear to differentiate between services and include the time in/time out, description of services, and staff signature for each unit billed.
    - Original Finding – No Documentation 05/07/2014.
      - Finding will be removed. Per remittance forms, agency did not bill services for CCS Individual H2021 HB U1 on this day.
    - Original Finding – 05/15/2014 – Agency billed 16 units of CCS Individual H2021 HB U1. Documentation received accounted for 10 units.
      - Finding is upheld. CCS note provided, however, unable to differentiate between CCS group services (T2021 HB U8) and CCS Individual services (H2021 HB U1). Only one note was provided which presumably documented both services, however, progress note documentation must be clear to differentiate between services and include the time in/time out, description of services, and staff signature for each unit billed.
    - Original Finding – 05/16/2014 – Agency billed 16 units of CCS Individual H2021 HB U1. Documentation received accounted for 3 units.
      - Finding is upheld. CCS note provided, however, unable to differentiate between CCS group services (T2021 HB U8) and CCS Individual services (H2021 HB U1). Only one note was provided which presumably documented both services, however, progress note documentation must be clear to differentiate between services and include the time in/time out, description of services, and staff signature for each unit billed.
    - Original Finding – No documentation 05/27, 28, 29 and 30, 2014.
      - Findings will be removed for these days. Documentation provided justifies billing for CCS Individual H2021 HB U1.
  - June 2014
    - Original Finding – 06/02/2014 – 06/06/2014 – Agency billed 120 units CCS (group) (T2021 HB U1). Documentation received accounted for 106 units.
      - Finding upheld: CCS note provided, however, unable to differentiate between CCS group services (T2021 HB U8) and CCS Individual services (H2021 HB U1). Only one note was provided which presumably documented both services, however, progress note documentation must be clear to differentiate between services and include the time in/time out, description of services, and staff signature for each unit billed. In addition, per documentation, only

120 total units were documented for 06/02-06/06/2014, however, a total of 184 units were billed for both CCS group (T2021 HB U8) and CCS Individual (H2021 HB U1)

- Original Finding - No documentation found for CCS Individual (H2021 HB U1) on 06/02, 03, 04, 05 and 06, 2014.
    - Finding upheld for the above dates. CCS notes provided, however, unable to differentiate between CCS group services (T2021 HB U8) and CCS Individual services (H2021 HB U1). Only one note was provided per day which presumably documented both services, however, progress note documentation must be clear to differentiate between services and include the time in/time out, description of services, and staff signature for each unit billed. In addition, per documentation, only 120 total units were documented for 06/02-06/06/2014 however, a combined total of 184 units were billed for both CCS group (T2021 HB U8) and CCS Individual (H2021 HB U1)
- Original Finding - No documentation found for CCS Individual (H2021 HB U1) on 06/09, 10 and 11, 2014.
    - Finding upheld for the above dates. CCS notes provided, however, unable to differentiate between CCS group services (T2021 HB U8) and CCS Individual services (H2021 HB U1). Only one note was provided per day which presumably documented both services, however, progress note documentation must be clear to differentiate between services and include the time in/time out, description of services, and staff signature for each unit billed. In addition, per documentation, only 120 total units were documented for 06/09-06/13/2014 however, a combined total of 171 units were billed for both CCS group (T2021 HB U8) and CCS Individual (H2021 HB U1)
- Original Finding - 06/09/2014 – 06/13/2014 – Agency billed 120 units of CCS Group (T2021 HB U8). Documentation received accounted for 96 units.
    - Finding upheld: CCS notes provided, however, unable to differentiate between CCS group services (T2021 HB U8) and CCS Individual services (H2021 HB U1). Only one note was provided per day which presumably documented both services, however, progress note documentation must be clear to differentiate between services and include the time in/time out, description of services, and staff signature for each unit billed. In addition, per documentation, only 96 total units were documented for 06/09-06/13/2014, however, a combined total of 171 units were billed for both CCS group (T2021 HB U8) and CCS Individual (H2021 HB U1). No documentation for 06/12/2014 provided.
- Original Finding - 06/16/2014-06/20/2014 – Agency billed 120 units CCS Group (T2021 HB U8). Documentation accounted for 84 units.
    - Finding Modified: Agency billed 120 units of CCS Group (T2021 HB U8) between 06/16/2014 – 06/20/2014. When taking into account CCS Individual time documented and billed, documentation provided accounted for 68 units.

        - Original Finding - No documentation for CCS Individual (H2021 HB U1) on 06/16, 17, 18 and 19, 2014.
            - Finding on 06/16/2014 modified: Agency billed 14 units of CCS Individual on 06/16/2014. Documentation provided accounted for 8 units.
            - Finding on 06/17/2014 modified: Agency billed 10 units of CCS Individual on 06/17/2014. Documentation provided accounted for 8 units.
            - Finding on 06/18/2014 upheld: Agency billed 23 units of CCS Individual on 06/18/2014. Documentation provided accounted for 0 units. No documentation provided
            - Finding removed: Agency billed 4 units of CCS Individual on 06/19/2014. Documentation provided accounted for all units billed.
        - Original Finding - No documentation for CCS Individual (H2021 HB U1) on 06/24, 25, 26, 27, and 30, 2014.
            - Findings upheld: No documentation provided to justify billing. Only billing documentation for CCS Group (T2021 HB U8) provided.
- Individual #5
    - May 2014
        - Original Finding - No documentation 05/27, 28, 29, 30
            - Finding Upheld: A final version of the Document Request Form which lists the above progress notes as missing was provided to the agency on 09/12/2014. Documentation was not presented to the survey team by the time of exit.
- Individual #6
    - May 2014
        - Original Finding - Agency billed 24 Units of CCS (group) (T2021 HB U8) on 05/06/2014. Documentation accounted for 0 units. No description of services provided. Progress note stated, "Not Scheduled Today."
            - Finding upheld: Documentation provided is the progress note which states "Not scheduled for today". No documentation provided to dispute the finding.
        - Original Finding - Agency billed 24 units off CCS Group (T2021 HB U8) on 05/09/2014. Documentation accounted for 0 units. Documentation did not include the date of service.
            - Finding upheld: Documentation provided is a progress note which still does not contain the date of service. No documentation provided to dispute the finding.
- Individual #7
    - May 2014
        - Original Finding - Agency billed 70 units of CCS group (T2021 HB U8) from 05/12-05/16/2014. Documentation accounted for 60 units.
            - Finding will be removed. Documentation provided justifies billing.
- Individual #9
    - May 2014
        - Original Finding - No documentation for CCS Individual (H2021 HB U1) on 05/01, 02, 05, 06, 07, 08, 09, 12, 13, 14 and 15-16, 2014
            - Findings for the above dates will be removed. Documentation provided justifies billing.

- Individual #10
  - May 2014
    - Original Finding - No documentation for CCS group (T2021 HB U7) on 05/01-02, 05-06, 09, 12-15, 16, 19, 20, 21, 22, 23, 27, 28-29 and 30, 2014.
      - Findings for the above dates will be removed. Documentation provided justifies billing.
    - Original Finding - No start/end time of service encounter for CCS individual (H2021 HB U1) on 05/05.
      - Finding will be removed.
    - Original Finding - 05/19/2014 – Agency billed 14 units of CCS Individual (H2021 HB U1). Documentation received accounted for 7 units.
      - Finding will be removed.
    - Original Finding - 05/20/2014 – Agency billed 18 units of CCS Individual (H2021 HB U1). Documentation accounted for 6 units.
      - Finding will be removed.
    - Original Finding - 05/23/2014 – Agency billed 14 units of CCS Individual (H2021 HB U1). Documentation accounted for 12units.
      - Finding will be removed.
    - Original Finding - 05/27/2014 – Agency billed 19.75 units of CCS Individual (H2021 HB U1). Documentation accounted for 18 units.
      - Finding will be removed.
  - June 2014
    - Original Finding - No documentation for CCS Individual (H2021 HB U1) on 06/02/2014
      - Finding will be removed.
    - Original Finding - 06/16/2014 – Agency billed 22 units of CCS Individual (H2021 HB U1). Documentation accounted for 12units.
      - Finding upheld. No documentation for 06/16/2014 for CCS Individual (H2021 HB U1) provided.
    - Original Finding - 06/26-27/2014 - Agency billed 32 units of CCS Individual (H2021 HB U1). Documentation accounted for 24 units.
      - Finding will be removed. Documentation provided justifies billing.
- Individual #11
  - June 2014
    - Original Finding - Agency billed 24 units of CCS group (T2021 HB U8) on 06/10/2014. No documentation found.
      - Finding removed. Documentation provided justifies billing.

<u>Regarding Tag #LS26/6L26</u>
Determination: The IRF committee is removing the original finding in the report of findings. Documentation provided supports billing for 05/27/2014 and 05/31/2014.

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

Thank you.
Respectfully,

Crystal Lopez-Beck

Crystal Lopez-Beck
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

Q.15.1.DDW.D1889.5.RTN.12.14.357

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

Date: January 15, 2015

To: Chitra Roy, Executive Director
Provider: Optihealth, Inc
Address: 4620 Jefferson Lane Suite A
State/Zip: Albuquerque, New Mexico 87109

E-mail Address: croy@optihealthnm.com

Region: Metro
Survey Date: September 8 - 12, 2014
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)
Survey Type: Routine

Dear Ms. Roy:

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 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,

Tony Fragua

Tony Fragua
Health Program Manager/Plan of Correction Coordinator
Quality Management Bureau/DHI

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