Date: April 4, 2011

To: Jyl Adair, Administrator
Provider: PMS - Project Shield
Address: 2015 E 12th Street
State/Zip: Farmington, New Mexico 87401

E-mail Address: jyl_adair@pmsnet.org

CC: Martha Wooten, NW Regional Director
E-Mail Address: martha_wooten@pmsnet.org

Region: Northwest
Survey Date: January 24 - 28, 2011
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Survey Type: Routine
Team Leader: Stephanie R. Martinez de Berenger, MPA, GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Cathy Saxton, BA, Developmental Disabilities Supports Division

Dear Ms. Adair

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 contracts. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Quality Management Compliance Determination:
The Division of Health Improvement is issuing your agency a determination of ñNon-Compliance with Conditions of Participation.ò

Plan of Correction:
The attached Report of Findings identifies deficiencies found during your agencyôs compliance review. You are required to complete and implement a Plan of Correction. Please submit your agencyôs Plan of Correction in the space on the two right columns of the Report of Findings. See attachment ñAò for additional guidance in completing the Plan of Correction. The response is due to the parties below within 10 business days of the receipt of this letter:

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 within 45 business days. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as all remedies must still be completed within 45 business days of the receipt of this letter.

Failure to submit, complete or implement your Plan of Correction within the 45 day required time frames 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 ñCòfor 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 business days. 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 at 505-222-8647 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,

Stephanie R. Martinez de Berenger, MPA, GCDF

Stephanie R. Martinez de Berenger, MPA, GCDF
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	January 24, 2011
Present:	**PMS Project Shield, Inc** Jyl Adair, Administrator Gina Sanchez, Service Coordinator Kresta Brown, Service Coordinator **DOH/DHI/QMB** Stephanie R. Martinez de Berenger, MPA, GCDF, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor
Exit Conference Date:	January 26, 2011
Present:	**PMS Project Shield, Inc** Jyl Adair, Administrator, Gina Sanchez, Service Coordinator **DOH/DHI/QMB** Stephanie R. Martinez de Berenger, MPA, GCDF, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor **DDSD - Northwest Regional Office** Cathy Saxton, Community Inclusion Coordinator
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 7 0 - *Jackson* Class Members 7 - Non-*Jackson* Class Members 6 - Adult Habilitation 6 - Community Access 6 - Supported Employment
Persons Served Interviewed	Number: 5
Persons Served Observed	Number: 2 (One Individual was unavailable for interviews during on-site visit and the other Individual was hospitalized at the time of the on-site survey)
Direct Service Personnel Interviewed	Number: 8
Records Reviewed (Persons Served) Administrative Files Reviewed	Number: 7 • Billing Records • Medical Records • Incident Management Records • Personnel Files • Training Records • Agency Policy and Procedure • Caregiver Criminal History Screening Records • Employee Abuse Registry • Human Rights Notes and/or Meeting Minutes • Evacuation Drills • 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 Review, your QMB Report of Findings will be sent to you via US 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 non compliance.

Agencies must submit their Plan of Correction within 10 business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 days will be referred to the Internal Review Committee [IRC] for sanctions).

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-222-8647 or email at George.Perrault@state.nm.us Requests for technical assistance must be requested through your DDSD Regional Office.

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) days of receiving your report. The POC process cannot resolve disputes regarding findings. Please note that you must still submit a POC for findings that are in question (see Attachment ñCò).

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 Agencyôs required, annual Quality Assurance Plan. (see page 3, DDW standards, effective; April 1, 2007, Chapter 1, Section I Continuous Quality Management System)

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 you submit needs to address ***each deficiency*** in the two right hand columns with:

1. How the corrective action will be accomplished for all cited deficiencies in the report of findings;
2. How your Agency will identify all other individuals having the potential to be affected by the same deficient practice;
3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur and corrective action is sustained;
4. How your Agency plans to monitor corrective actions utilizing its continuous Quality Assurance/Quality Improvement Plan to assure solutions in the plan of correction are achieved and sustained, including (if appropriate):
    - 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, Incident Reporting, and Individual-Specific service requirements, etc;
    - How accuracy in Billing documentation is assured;

- How health, safety is assured;
- For Case Management Providers, how ISPs 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, and
- Details about Quality Targets in various areas, current status, Root Cause Analyses about why Targets were not met, and remedies implemented.

5. The individualõs title responsible for the Plan of Correction and completion date.

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 should 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). Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 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.

Plan of Correction Submission Requirements

1. Your 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. If you have questions about the POC process, call the POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
    a. Electronically at George.Perrault@state.nm.us
    b. Faxed to 505-222-8661, or
    c. Mailed to QMB, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not send supporting documentation to QMB until after your POC has been approved by QMB.
6. QMB will notify you when your POC has been ñapproveòor ñdenied.ò
    a. Whether your POC is ñapproved,òor ñdenied,òyou 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 ñDeniedòit must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
    c. If your POC is ñDeniedòa second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation that your POC has been approved by QMB and a final deadline for completion of your POC.

7. Failure to submit your POC within 10 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.
8. 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 at QMB, 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.

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. You may submit your documents by postal mail, fax, or electronically on disc or 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; hard copies or scanned and electronically submitted copies are fine. 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. For billing deficiencies, you must submit:
    a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
    b. Copies of ñvoid and adjustòforms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

Attachment B

QMB Scope and Severity Matrix

Each deficiency in your Report of Findings is scored on a Scope and Severity Scale. The culmination of each deficiencyôs Scope and Severity is used to determine degree of compliance to standards and regulations and level of QMB Compliance Determination.

			SCOPE		
			Isolated 01% - 15%	**Pattern 16% - 79%**	**Widespread 80% - 100%**
SEVERITY	**High Impact**	Immediate Jeopardy to individual health and or safety	**J.**	**K.**	**L.**
		Actual harm	**G.**	**H.**	**I.**
	Medium Impact	No Actual Harm Potential for more than minimal harm	**D.**	**E.**	**F.** (3 or more)
			D. (2 or less)		**F.** (no conditions of participation)
	Low Impact	No Actual Harm Minimal potential for harm.	**A.**	**B.**	**C.**

Scope and Severity Definitions:

- Isolated:

A deficiency that is limited to 1% to 15% of the sample, usually impacting few individuals in the sample.

- Pattern:

A deficiency that impacts a number or group of individuals from 16% to 79% of the sample is defined as a pattern finding. Pattern findings suggest the need for system wide corrective actions.

- Widespread:

A deficiency that impacts most or all (80% to 100%) of the individuals in the sample is defined as widespread or pervasive. Widespread findings suggest the need for system wide corrective actions as well as the need to implement a Continuous Quality Improvement process to improve or build infrastructure. Widespread findings could be referred to the Internal Review Committee for review and possible actions or sanctions.

QMB Determinations of Compliance

- ñSubstantial Compliance with Conditions of Participationò

The QMB determination of ñSubstantial Compliance with Conditions of Participationòindicates that a provider is in substantial compliance with all óConditions of Participationôand other standards and regulations. The agency has obtained a level of compliance such that there is a minimal potential for harm to individualsôhealth and safety. To qualify for a determination of Substantial Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation.

- ñNon-Compliance with Conditions of Participationò

The QMB determination of ñNon-Compliance with Conditions of Participationòindicates that a provider is out of compliance with one (1) or more óConditions of Participation.ôThis non-compliance, if not corrected, is likely to result in a serious negative outcome or the potential for more than minimal harm to individualsô health and safety.

Providers receiving a repeat determination of óNon-Complianceômay be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- ñSub-Standard Compliance with Conditions of Participationò

The QMB determination of ñSub-Standard Compliance with Conditions of Participationòindicates a provider is significantly out of compliance with Conditions of Participation and/or has:

- Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
- Any finding of actual harm or Immediate Jeopardy.

Providers receiving a repeat determination of óSubstandard Complianceôwill be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

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 that surveyors have clarified issues and/or requested missing information before completing the review. 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 in writing to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.

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.

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received within 10 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 QMB compliance determination or the length of their DDSD provider contract.

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

QMB has 30 working days to complete the review and notify the provider of the decision. The request will be reviewed by the IRF committee. 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: **PMS - Project Shield - Northwest Region**
Program: Developmental Disabilities Waiver
Service: Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Routine Survey
Date of Survey: **January 24 - 28, 2011**

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A05 (CoP) General Requirements	**Scope and Severity Rating: F**		
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. **A. General Requirements:** (2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.	Based on record review, the Agency failed to update its written policies and procedures every three years or as needed. The following polices and procedures provided during the on-site survey (01/24/2011) showed no evidence of being reviewed every three years or being updated as needed: • ñEmergency Evacuation ï Last reviewed and/or revised December 1996.	[ ]	[]

Tag # 1A08 Agency Case File	Scope and Severity Rating: B		
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. **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 individualõs case file shall include the following requirements: (1) Emergency contact information, including the individualõs address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individualõs complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 2 of 7 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current: • Occupational Therapy Plan (#5) • **Dental Exam** ◦ Individual #2 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • **Auditory Exam** ◦ Individual #2 - As indicated by collateral documentation reviewed, the exam was completed on 06/2007. No evidence of exam was found.	[ ]	[]

developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.			

Tag # 1A09.1 Medication Delivery - PRN Medication	Scope and Severity Rating: F		
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 physicianôs written or licensed health care providerôs 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	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 2 of 2 Individuals Individual #1 October 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period. • Risperdal 4mg (PRN) November 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period. • Risperdal 4mg (PRN) December 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Risperdal 4mg (PRN) Individual #5 November 2010 Medication Administration Records did not contain the route of administration for the following medications: • Ferrous Sulfate 325 mg (PRN)	[ ]	[ ]

(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; **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. **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 individualõs response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurseõs assessment of the individual and consideration of the individualõs diagnoses, health status, stability, utilization of PRN medications and level of support required by the individualõs 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 individualõs 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 ï 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.).			

Tag # 1A11.1 (CoP) Transportation Training	Scope and Severity Rating: E		
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. **G. Transportation:** Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy 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, and which are consistent with DDSD guidelines issued July 1, 1999 titled ñClient Transportation Safetyò The policy and procedures must address at least the following topics: (1) Driversôrequirements, (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (3) Vehicle maintenance and safety inspections, (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures, (5) Emergency Plans, including vehicle evacuation techniques, (6) Documentation, and (7) Accident Procedures. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy** Training Requirements for Direct Service Agency Staff Policy **Eff Date:** March 1, 2007	Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 3 of 16 Direct Service Professionals. No documented evidence was found of the following required training: • Transportation (DSP #42, 44 & 49) 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 #44 stated, ñNot really.ò	[ ]	[ ]

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 driverôs 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 staffôs role) 6. Wheelchair tie-down procedures (if applicable to the staffôs role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)			

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **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 ñAddendum Bò) training requirements in	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 4 of 16 Direct Service Professionals. Review of Direct Service Professional training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #48) • Person-Centered Planning (1-Day) (DSP #48) • First Aid (DSP #46) • CPR (DSP #41 & 46) • Assisting With Medication Delivery (DSP #54) • Participatory Communication & Choice Making (DSP #46) • Level 1 Health (DSP #46) • Positive Behavior Supports Strategies (DSP #46)	[ ]	[]

accordance with the specifications described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines. F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001. 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.			

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: D		
NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employeeôs personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With	Based on record review, the Agency failed to maintain documentation in the employeeôs personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 1 of 18 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** • #53 ï Date of hire 01/17/2011. Completed 01/25/2011.	[ ]	[]

respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individualõs current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements.** **D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employeeõs qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.			

Tag # 1A28.2 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: E		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **E. Consumer and Guardian Orientation Packet:** Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumerôs file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 2 of 7 individuals. • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#1 & 5)	[ ]	[ ]

Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: A		
NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a clientõs rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a clientõs rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service providerõs complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service providerõs complaint or grievance procedure	Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 7 individuals. • Grievance/Complaint Procedure Acknowledgement (#5)	[ ]	[ ]

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: E		
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 failed to 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 2 of 7 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • ñIndividual #1 will introduce herself to someone during swim sessionòAs indicated by the ISP this is to be completed bi-weekly. Review of Agencyôs Outcome Data Tracking for December 1 ï 30, 2010 showed the frequency was not being completed as required. Individual #3 • ñIndividual #3 with assistance will find a craft to complete.òAs indicated by the ISP this is to be completed weekly. Review of Agencyôs Outcome Data Tracking for December 1 ï 30, 2010 showed the frequency was not being completed as required. • ñIndividual #3 will work on this craft until complete.ò As indicated by the ISP this is to be completed weekly. Review of Agencyôs Outcome Data Tracking for December 1 ï 30, 2010 showed the frequency was not being completed as required.	[ ]	[]

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **E. Provider Agency Reporting Requirements:** All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD.	Based on record review, the Agency failed to complete quarterly reports as required for 3 of 7 individuals receiving Community Inclusion services. **Adult Habilitation Quarterly Reports** • Individual #1 - None found for 09/2010 - 11/2010 • Individual #2 - None found for 10/2010 - 12/2010 • Individual #4 – None found for 9/2010 - 11/2010 **Community Access Quarterly Reports** • Individual #1 - None found for 09/2010 - 11/2010 • Individual #2 - None found for 10/2010 - 12/2010 • Individual #4 – None found for 09/2010 - 11/2010	[ ]	[ ]

Tag # 5I36 CA Reimbursement	Scope and Severity Rating: A		
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 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS**	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 1 of 6 individuals. Individual #1 November 2010 • The Agency billed 16 units of Community Access on 11/10/2010. Documentation did not contain start and end time on 11/10/2010 to justify billing.	[ ]	[]

G. Reimbursement (1) Billable Unit**:** A billable unit is defined as one-quarter hour of service. (2) Billable Activities**:** The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed 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 is tied directly to the individual's ISP, Action Plan; (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and (c) Non face-to-face hours do not exceed 10% of the monthly billable hours. (3) Non-Billable Activities**:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include: (a) Time and expense for training service personnel; (b) Supervision of agency staff; (c) Service documentation and billing activities; or (d) Time the individual spends in segregated facility-based settings activities.			
Tag # 5I44 AH Reimbursement	**Scope and Severity Rating: B**		

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 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 2 of 6 individuals. Individual #4 October 2010 • The Agency billed 78 units of Adult Habilitation from 10/01/2010 through 10/29/2010. Documentation received accounted for 71 units. November 2010 • The Agency billed 117 units of Adult Habilitation from 11/01/2010 through 11/30/2010. Documentation received accounted for 115 units. Individual #7 October 2010 • The Agency billed 289 units of Adult Habilitation from 10/01/2010 through 10/28/2010. Documentation received accounted for 273 units.	[ ]	[]

is based on the individualõs 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			

Date: July 8, 2011

To: Ms. Jyl Adair, Administrator

Provider: PMS Project Shield
Address: 2015 East 12th Street
State/Zip: Farmington, New Mexico 87401

Cc (email): Ms. Pippa Amick, PMS
Ms. Martha Wooten, NW Regional Director

Region: Northwest
Survey Date: January 24 - 28, 2011
Program Surveyed: Developmental Disabilities Waiver
Services Surveyed: Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Survey Type: Routine

Dear Ms. Adair:

The Division of Health Improvement Quality Management Bureau received, reviewed and approved the documents you submitted for your Plan of Correction. The documents you provided verified that all survey Deficiencies were corrected.

The Plan of Correction process is now complete.

To maintain ongoing compliance with regulations and Standards, continue to use the Quality Improvement processes described in your Plan of Correction, including:

- PMS SHIELD will institute quarterly chart audits to ensure proper documentation is filed and that records are complete.
- PMS nurse meets with SHIELD STAFF every Friday to provide ongoing in-servicing and education on ongoing medical or medication issues for SHIELD clients
- PMS nurse will review all MARS on a quarterly basis and will document for results.
  PMS SHIELD will ensure that all new hires are trained within 2 weeks of hire in regards to the safe operation of the vehicle, assisting passengers and safe lifting procedures. The date and time, and trainer, for all training sessions, as well as attendance will be documented. This training will be added to the New Competency Checklist
- The Administrative Assistant will review the training database on a monthly basis and will provide a report to the Administrator.
- PMS's HR Manager reviews all new hire documentation packets in addition to two other corporate HR staff.
- Parent/guardian/client Incident Management Training acknowledgement form and the Grievance form are part of the intake packet. A tracking spreadsheet has been developed to show when the annual intake is to be completed. The renewal date will be put into the Program Assistance calendar to provide a reminder.
- PMS SHIELD has a tracking spreadsheet to ensure that Quarterly Reports will be completed by the 14th of the month they are due. The spreadsheet shows when the quarterly reports are due for each client. These dates will be put into a calendar to remind the supervisor of the upcoming report.

- The Support Instructors, Supervisor and Billing Specialist will ensure that all start and end times are entered prior to submitting for reimbursement.
- On a quarterly basis 25% of clients will be audited for billing accuracy. An audit tool will be developed by 5/30/11

Consistent implementation of your QA/QI processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer Deficiencies in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, and for the work you and your team perform.

Sincerely,

George Perrault, MBA
Plan of Correction Coordinator

Cc: DHI
DDSD