Date: April 3, 2013

To: Jyl Adair, Executive Director
Provider: PMS dba Project Shield
Address: 620 Dekalb
State/Zip: Farmington, New Mexico 87401

E-mail Address: jyl_adair@pmsnet.org
mike_renaud@pmsnet.org

CC: Susan Smith, Board Chair
Address: 620 Dekalb
State/Zip: Farmington, New Mexico 87401

Region: Northwest
Survey Date: February 11 - 14, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Inclusion Supports (Adult Habilitation, Community Access and Supported Employment)
Survey Type: Routine
Team Leader: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Meg Pell, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

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

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

Partial Compliance with Conditions of Participation

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

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

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

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

1. **Quality Management Bureau, Attention: 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 at 505-699-9356 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,

Tony Fragua, BFA

Tony Fragua, BFA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	February 11, 2013	
Present:	**PMS dba Project Shield** Gina Sanchez, Supported Employment Supervisor **DOH/DHI/QMB** Tony Fragua, BFA, Team Lead/Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor Meg Pell, BA, Healthcare Surveyor	
Exit Conference Date:	February 13, 2013	
Present:	**PMS dba Project Shield** Mike Renaud, Northwest Region Director Shanin Arp, Support Services Supervisor Gina Sanchez Supported Employment Supervisor **DOH/DHI/QMB** Tony Fragua, BFA, Team Lead/Healthcare Surveyor Meg Pell, BA, Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor **DDSD – Northwest Regional Office** Cathy Saxton, Regional Case Manager Coordinator	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	10 1 - *Jackson* Class Members 9 - Non-*Jackson* Class Members 10 - Adult Habilitation 8 - Community Access 4 - Supported Employment
Persons Served Records Reviewed	Number:	10
Persons Served Interviewed	Number:	5
Persons Served Observed	Number:	5 (5 Individuals not available during the on-site survey)
Direct Support Personnel Interviewed	Number:	6
Direct Support Personnel Records Reviewed	Number:	23
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
- 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
- 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 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 business days will 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 shall be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-699-9356 or email at Crystal.Lopez-Beck@state.nm.us. Requests for technical assistance must be requested through your DDSD Regional 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 required six CMS core elements to address each deficiency of the POC:

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 POC:

- 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, 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 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) 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 QMB POC Coordinator, Crystal Lopez-Beck at 505-699-9356 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:
    a. Electronically at Crystal.Lopez-Beck@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 “approve” 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.

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. You may submit your documents by postal mail (paper hard copy or on a disc), fax, or 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. 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 “void and adjust” forms submitted to correct all over-billed or unjustified units billed identified 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 Deputy Chief 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.

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, Scott Good at scott.good@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: **PMS dba Project Shield – Northwest Region**
Program: Developmental Disabilities Waiver
Service: Community Inclusion Supports (Adult Habilitation, Community Access and Supported Employment)
Monitoring Type: Routine Survey
Survey Date: **February 11 – 14, 2013**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
CMS Assurance – 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 **Agency Case File**	**Standard Level Deficiency**		
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 individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives,	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 5 of 10 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • **Current Emergency and Personal Identification Information** ◦ Did not contain Individual's current address (#9) ◦ Did not contain Physician's phone number (#4) • Physical Therapy Plan (#1) • Documentation of Guardianship/Power of Attorney (#3) • **Dental Exam** ◦ Individual #5 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. 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: →	

or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital. **NMAC 8.302.1.17 RECORD KEEPING AND**	• **Vision Exam** ◦ Individual #3 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #5 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. • **Auditory Exam** ◦ Individual #9 - As indicated by collateral documentation reviewed, exam was completed on 4/20/2009. Follow-up was to be completed in 2 years. No evidence of follow-up found.		

DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.			

Tag # 1A08.1 Agency Case File - Progress Notes	Standard Level Deficiency		
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 individual's case file shall include the following requirements: (3) Progress notes and other service delivery documentation;	Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 2 of 10 Individuals. **Supported Employment Progress Notes/Daily Contact Logs** • Individual #9 - None found for 11/3/2012 • Individual #10 - None found for 11/12/2012 and 12/7/2012.	**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 # 1A32 and 6L14 Individual Service Plan Implementation	Condition of Participation 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency 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 9 of 10 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #2 • Per Work/Learn Outcome, Action Steps for "… will water and care for plants," is to be completed weekly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012. Individual #3 • Per Live Outcome, Action Steps for "… with staff assistance will perform a hygiene task (tooth brushing, toileting, bathing, etc.)" is to be completed 4 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012. • Per Live Outcome, Action Steps for "… will,	**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: →	

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]	with staff assistance will learn to assume responsibility for hygiene task," is to be completed 4 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012. • Per Work/Learn Outcome, Action Steps for "… with staff assistance will select two sporting events to attend or participate in monthly" is to be completed 1 time per month evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012. • Per Work/Learn Outcome, Actions Steps for "… with staff assistance will attend or participate in two sporting events monthly," is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012. • Per Develop Relationships/Have Fun Outcome, Action Steps for "… with staff assistance, will select two events for attendance," is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012. • Per Develop Relationships/Have Fun Outcome, Action Steps for "… with staff assistance, will attend two community events monthly," is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012.		

	Individual #4 • Work/Learn/Volunteer Outcome, "… will independently greet and respond to others by saying 'hi or hello,' Action Step "with prompts …will greet people as they come into Shield with a 'hi or hello,' is to be completed 1 time per day. Outcome/Action Step was not being completed at the required frequency as indicated in the ISP for 12/2012. Individual #5 • Per Develop Relationships/Have Fun Outcome, Action Steps for "… will takes pictures of things that interest him," is to be completed 1 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 – 12/2012. • Per Develop Relationships/Have Fun Outcome, Action Steps for "… will choose the pictures that he likes and print them," is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 – 12/2012. • Per Develop Relationships/Have Fun Outcome, Action Steps for "… will add the pictures of his choice to his journal," is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 – 12/2012. • Per Health/Other Outcome, Action Steps for "… will go walking, bowling, swimming, and play basketball," is to be completed 4 times per week. Evidence found indicated it was		

	not being completed at the required frequency as indicated in the ISP for 10/2012 – 12/2012. • Per Health/ Other Outcome, Action Steps for "… will make healthy food choices," is to be completed 5 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 – 12/2012. Individual #6 • None found regarding: Work/Learn/Volunteer Outcome "… will learn to prepare his lunch with no more than 5 verbal prompts," for12/2012. • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Work/Learn/Volunteer Outcome. Agency's daily documentation for Work/Learn/Volunteer Outcomes/Action Steps are as follows: ◦ *"… will learn 2 volunteer tasks at the Nature Center."* ◦ *"… will take 5 steps in the water without holding onto the wall."* Annual ISP Work/Learn/Volunteer Outcomes/Action Steps are as follows: ◦ "… will learn to prepare his lunch with no more than 5 verbal prompts." Individual #7 • Per Work/Learn Outcome, "… will take pictures of 12 activities," Action Steps for "… will choose activities to participate in," is to		

	be completed 1 time per month, Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012. • Per Work/Learn Outcome, "… will take pictures of 12 activities." Action Steps for "… will take pictures and develop them with staff assistance," is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012. • Per Develop Relationship/Have Fun Outcome, "… will make a scrapbook" Action Steps for "… will show his scrapbook to others," is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012. Individual #8 • Per Work/Learn/Volunteer Outcome, "… will learn to recognize 4 sign language signs (toilet/bathroom, more, eat, trike)," is to be completed daily. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012. • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Work/Learn/Volunteer Outcome. For time period 12/3/2012 – 12/13/2012. Agency's daily documentation for the Work/Learn/Volunteer Outcomes/Action Steps are as follows:		

	◦ *"… will independently use his iPad."* ◦ *"… will volunteer 40 hours of his time."* ◦ *"… will write the letter J independently."* Annual ISP Work/Learn/Volunteer Outcomes/Action Steps are as follows: ◦ "… will learn to recognize 4 sign language signs (toilet/bathroom, more, eat, trike)." ◦ "…will take 12 relaxation or animal trips in the 4 corner area." Individual #9 • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Work/Learn/Volunteer Outcome. For time period 12/3/2012 – 12/14/2012. Agency's daily documentation for the Develop Relationship/Have Fun Outcomes/Action Steps are as follows: ◦ *"… will have her portrait taken."* ◦ *"… will participate in 26 soothing activities of her choice."* ◦ *"… will create 24 functional art pieces."* Annual ISP Live Outcomes are as follows: ◦ "… will create holiday gifts to give to others 6 times." Annual ISP Develop Relationships/Have Fun Outcomes/Action Steps are as follows: ◦ "… will invite 5 people she has lost contact with to join her for a lunch meal." ◦ "… will create a scrapbook depicting her		

	life and relationships." • Per Develop Relationships/Have Fun Outcome, "… will create a scrapbook depicting her life and relationships," Action Steps for "… with assistance will gather photos and other items necessary for inclusion in her scrapbook," is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012. • Per Develop Relationships/Have Fun Outcome "… will create a scrapbook depicting her life and relationships. " Action Steps for "… with assistance will place photos and other items in her scrapbook" is to be completed 1 time per month evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2012. **Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • No Outcomes or DDSD exemption/Decision Consultation found for Community Access Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver." Individual #3 • Per Live Outcome, Action Steps for "… with staff assistance will perform a hygiene task (tooth brushing, toileting, bathing, etc.)," is		

	to be completed 4 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 - 12/2012. • Per Live Outcome, Action Steps for "… will, with staff assistance will learn to assume responsibility for hygiene task," is to be completed 4 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 - 12/2012. • Per Work/Learn Outcome, Action Steps for "… with staff assistance will select two sporting events to attend or participate in monthly" is to be completed 1 time per month evidence found indicated it was not being completed at the required frequency indicated in the ISP for 11/2012 - 12/2012. • Per Work/Learn Outcome, Action Steps for "… with staff assistance will attend or participate in two sporting events monthly," is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 - 12/2012. • Per Develop Relationships/Have Fun Outcome, Action Steps for "…with staff assistance, will select two events for attendance," is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 - 12/2012. • Per Develop Relationships/Have Fun Outcome, Action Steps for "…with staff		

	assistance, will attend two community events monthly," is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 and 12/2012. Individual #4 • Work/Learn/Volunteer Outcome "…will independently greet and respond to others by saying "hi or hello." Action Step "With prompts …. will greet people as they come into Shield with a "hi or hello" is to be completed 1 time per day. Outcome/Action Step was not being completed at the required frequency for 12/2012. Individual #5 • Per Develop Relationships/Have Fun Outcome, Action Steps for "…will takes pictures of things that interest him," is to be completed 1 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 – 12/2012. • Per Develop Relationships/Have Fun Outcome, Action Steps for "…will choose the pictures that he likes and print them," is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 – 12/2012. • Per Develop Relationships/Have Fun Outcome, Action Steps for "…will add the pictures of his choice to his journal," is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the		

	ISP for 10/2012 – 12/2012. • Per Health/Other Outcome Action Steps for "…will go walking, bowling, swimming, and play basketball," is to be completed 4 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 – 12/2012. • Per Health/Other Outcome Action Steps for "…will make healthy food choice," is to be completed 5 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 – 12/2012. Individual #6 • None found regarding: Work/Learn/Volunteer Outcome "…will learn to use 2 floatation devices independently," for 12/2012 • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Work/Learn/Volunteer Outcome. Agency's daily documentation for Outcomes/Action Steps are as follows: ◦ *"… will learn 2 volunteer tasks at the Nature Center."* ◦ *"… will take 5 steps in the water without holding onto the wall."* Annual ISP Work/Learn/Volunteer Outcomes/Action Steps are as follows: ◦ "… will learn to use 2 flotation devices independently."		

	Individual #7 • Per Work/Learn Outcome; "…will take pictures of 12 activities." Action Steps for "… will choose activities to participate in," is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 - 12/2012. • Per Work/Learn Outcome; "…will take pictures of 12 activities." Action Steps for "…will take pictures and develop them with staff assistance," is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 - 12/2012. • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Work/Learn/Volunteer Outcome. No documentation was found regarding implementation of ISP outcomes for 10/2012 – 12/2012. Agency's daily documentation for the Work/Learn/Volunteer Outcomes/Action Steps are as follows: ◦ *"…will attend 2 classes that will teach me more about big trucks and how to drive them."* ◦ *"I will volunteer 104 hours of my time at ECHO food bank."* ◦ *"… will take one vacation."* ◦ *"… will tour two local radio stations."*		

	Annual ISP Work/Learn/Volunteer Outcomes/Action Steps are as follows: ◦ *"….will take pictures of 12 activities."* ◦ *"….will get a job that interests him."* ◦ *"…will co-facilitate 4 CPR trainings with pay."* Individual #8 • Per Work/Learn/Volunteer Outcome "…will learn to recognize 4 sign language signs (toilet/bathroom, more, eat, trike)," is to be completed daily. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 - 12/2012. • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Work/Learn/Volunteer Outcome. For time period 10/2012 – 12/2012. Agency's daily documentation for the Work/Learn/Volunteer Outcomes/Action Steps are as follows: ◦ *"… will independently use his iPad."* ◦ *"… will volunteer 40 hours of his time."* ◦ *"… will write the letter J independently."* Annual ISP Work/Learn/Volunteer Outcomes/Action Steps are as follows: ◦ "… will learn to recognize 4 sign language signs (toilet/bathroom, more, eat, trike)." ◦ "…will take 12 relaxation or animal trips in		

	the 4 corner area." Individual #9 • No Outcomes or DDSD exemption/Decision Consultation found for Community Access Services. As indicated by NMAC 7.26.5.14. "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver."		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
CMS Assurance – 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**		
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… **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	Based on record review, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 2 of 23 Direct Support Personnel. **No documented evidence was found of the following required training:** • Transportation (DSP #52, 59)	**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: →	

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)			

Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency		
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**	Based on record review, the Agency failed to ensure Orientation and Training requirements were met for 9 of 23 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #50) • First Aid (DSP #45, 50, 56, 61, 62) • CPR (DSP #50, 56, 61, 62) • Assisting With Medication Delivery (DSP #47, 53, 57, 62) • Participatory Communication and Choice Making (DSP #51)	**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: →	

Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines. F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in 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 service.			

Tag # 1A22 Agency Personnel Competency	Standard Level Deficiency		
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. **F. Qualifications for Direct Service Personnel:** The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the	Based on interview, the Agency failed to ensure training competencies were met for 3 of 6 Direct Support Personnel. **When DSP were asked if they received training on the Individual's Service Plan and what the plan covered, the following was reported:** • DSP #44 stated, "Briefly trained, no." DSP #44 was unable to give examples of what was covered in ISP. (Individual #10) **When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:** • DSP #44 stated, "Yes she has a plan, she hasn't really had a behavior, I have not been trained." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #1) **When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #44 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #1) **When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan 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: →	

individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes. **Department of Health (DOH) Developmental**	• DSP #44 stated, "Yes, she has a plan. I haven't been trained and I don't know what it covers." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #1) **When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:** • DSP #47 stated, "Only seizures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for Aspiration Risk and Skin/Wound. (Individual #3) • DSP #47 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Weight/Body Mass Index and Bowel and Bladder. (Individual #4) • DSP #43 stated, "No." According to the Individual Specific Training section of the ISP, the Individual requires Health Care Plans for Bowel and Bladder. Additionally as indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Weight/Body Mass Index (Individual #6) • DSP #44 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Weight/Body Mass Index. (Individual #10)		

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.			

Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	Standard Level Deficiency		
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 employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 3 of 25 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Personnel (DSP):** • #51 – Date of hire 5/26/2009, completed 9/02/2011. • #58 – Date of hire 6/20/2008, completed 1/20/2010. • #59 – Date of hire 6/08/2009, completed 2/18/2010.	**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: →	

employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. 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 employee's 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 # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency		
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. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or 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:**	Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 9 of 25 Agency Personnel. **Direct Support Personnel (DSP):** • Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (DSP# 41, 45, 49, 52, 55, 57, 61, 62) **Service Coordination Personnel (SC):** • Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (SC #64)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.			

Tag # 1A36 Service Coordination Requirements	Standard Level Deficiency		
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 **NMAC 7.26.5.7** "service coordinator": the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 2 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: • Person Centered Planning (2-Day) (SC #63) • Advocacy Strategies (SC #63) • Sexuality for People with Developmental Disabilities (SC #63) • Level 1 Health (SC #63)	**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: →	

community service provider agency **NMAC 7.26.5.11** (b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the service coordinators shall assure the action plans and strategies are implemented consistent with the provisions of the ISP, and shall report to the case manager on ISP implementation and the individual's progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more "key" community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDTs selection are set forth as follows: (i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations; (ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations; (iii) the designated service coordinator shall be familiar with and understand community service delivery and supports; (iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
CMS Assurance – 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 # 1A03 CQI System	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health	Based on record review and interview, the Agency had not fully implemented their Continuous Quality Management System as required by standard and the DDSD Provider Agreement. • Review of the findings identified during the on-site survey (February 11 – 14, 2013) and as reflected in this report of findings, the Agency had multiple deficiencies noted, including one at the level of a Condition of Participation; which indicates the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.	**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: →	

events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:** **E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system: **(1)** community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements; **(2)** community based service providers providing developmental disabilities services must have a designated incident management coordinator in place; **(4)** community based service providers			

providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.			

Tag # 1A15.2 and 5I09 Healthcare Documentation	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities** (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these	Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 4 of 10 individual Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: • Electronic Comprehensive Health Assessment Tool (eChat) (#2) • Medication Administration Assessment Tool (#1, 2) • Aspiration Risk Screening Tool (#1, 8) • **Health Care Plans** • *Skin and Wound* Individual #9 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Oral Care* Individual #9 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Seizures* Individual #9 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Constipation* Individual #9 - According to Electronic	**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: →	

assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request. (c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. (d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency,	Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Respiratory* Individual #9 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • **Medical Emergency Response Plans** • *Falls* ◦ Individual #9 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Sleep Apnea* ◦ Individual #9 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.		

method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **(2) Health related plans** (a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional. (b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. (c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. (d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings. (3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended): (a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain			

a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition. (b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal. (c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan. (d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions. (e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings. (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization. (g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author.			

(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed. **(4) General Nursing Documentation** (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person. (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **B. IDT Coordination** (1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and (2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.			

Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010 F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911. 5. Emergency contacts with phone numbers. 6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.			

Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency		
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 consumer's 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 1 of 10 individuals. • Parent/Guardian Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (#6)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Tag # 1A29 Complaints / Grievances Acknowledgement	Standard Level Deficiency		
NMAC 7.26.3.6 A These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's 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 10 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: • Grievance/Complaint Procedure Acknowledgement (#6)	**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: →	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
CMS Assurance – Medicaid Billing/Reimbursement/Financial Accountability – *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 # 5I25 **Supported Employment 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	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 2 of 4 individuals Individual #9 November 2012 • The Agency billed 2.25 hours of Supported Employment (T2013 U2) on 11/3/2012. Documentation accounted for 0 hours. One or more of the following elements was not met: ➢ No documentation found. December 2012 • The Agency billed 4 hours of Supported Employment (T2013 U2) on 12/7/2012. Documentation received accounted for 2 hours. • The Agency billed 3 hours of Supported Employment (T2013 U3) on 12/27/2012. Documentation received accounted for 1.75 hours. Individual #10 November 2012 • The Agency billed 1.5 hours of Supported Employment (T2013 U2) on 11/12/2012. Documentation accounted for 0 hours. One or more of the following 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: →	

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 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS** **E. Reimbursement** (1) Billable Unit: (a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job. (b) The **billable unit for Individual Supported Employment** is one hour with a maximum of four hours a month. The Individual Supported Employment hourly rate is for face-to-face time which is supported by non face-to-face activities as specified in the ISP and the performance based contract as negotiated annually with the provider agency. Individual Supported Employment is a minimum of one unit per month. If an individual needs less then one hour of face-to-face service per month the IDT Members shall consider whether Supported Employment Services need to be continued. Examples of non face-to-face services include: (i) Researching potential employers via telephone, Internet, or visits; (ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents; (iii) Arranging appointments for job tours, interviews, and job trials; (iv) Documenting job search and	December 2012 • The Agency billed 1.5 hours of Supported Employment (T2013 U3) on 12/7/2012. Documentation accounted for 0 hours. One or more of the following elements was not met: ➢ No documentation found.		

acquisition progress; (v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual's progress, needs and satisfaction; and (vi) Meetings with individual surrounding job development or retention not at the employer's site. (c) Intensive Supported Employment services are intended for individuals who need one-to-one, face-to-face support for 32 or more hours per month. The billable unit is one hour. (d) Group Supported Employment is a fifteen-minute unit. (e) Self-employment is a fifteen minute unit. (4) Billable Activities include: (a) Activities conducted within the scope of services; (b) Job development and related activities for up to ninety (90) calendar days) that result in employment of the individual for at least thirty (30) calendar days; and (c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDSD Regional Office.			

Tag # 5I36 Community Access 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 that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 5 of 8 individuals. Individual #2 October 2012 • The Agency billed 28 units of Community Access (H2021 U1) from 10/1/2012 through 10/31/2012. Documentation did not contain the required elements on 10/12/2012. Documentation received accounted for 22 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. November 2012 • The Agency billed 40 units of Community Access (H2021 U1) from 11/1/2012 through 11/30/2012. Documentation did not contain the required elements on 11/9, 21, 30. Documentation received accounted for 26 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. December 2012 • The Agency billed 27 units of Community Access (H2021 U1) from 12/1/2012 through 12/31/2012. Documentation did not contain the required elements on 12/7, 14, 26. Documentation received accounted for 15 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service.	**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: →	

recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS** **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.	Individual #3 October 2012 • The Agency billed 111 units of Community Access (H2021 U1) from 10/1/2012 through 10/31/2012. Documentation did not contain the required elements on 10/3, 15, 26. Documentation received accounted for 91 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. November 2012 • The Agency billed 180 units of Community Access (H2021 U1) from 11/1/2012 through 11/30/2012. Documentation received accounted for 178 units. December 2012 • The Agency billed 107 units of Community Access (H2021 U1) from 12/1/2012 through 12/31/2012. Documentation did not contain the required elements on 12/4, 5, 6, 10, 13, 20, 27, 28. Documentation received accounted for 46 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. Individual #5 November 2012 • The Agency billed 80 units of Community Access (H2021 U1) from 11/1/2012 through 11/30/2012. Documentation did not contain the required elements on 11/30/2012. Documentation received accounted for 76 units. One or more of the following elements was not met: ➢ The signature or authenticated name of		

	staff providing the service. December 2012 • The Agency billed 54 units of Community Access (H2021 U1) from 12/1/2012 through 12/31/2012. Documentation did not contain the required elements on 12/5, 6, 10, 13, 20. Documentation received accounted for 42 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. Individual #7 October 2012 • The Agency billed 38 units of Community Access (H2021 U1) from 10/1/2012 through 10/31/2012. Documentation did not contain the required elements on 10/10, 17. Documentation received accounted for 22 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. November 2012 • The Agency billed 13 units of Community Access (H2021 U1) from 11/1/2012 through 11/30/2012. Documentation did not contain the required elements on 11/12/2012. Documentation received accounted for 9 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. Individual #8 October 2012 • The Agency billed 170 units of Community Access (H2021 U1) from 10/1/2012 through		

	10/31/2012. Documentation did not contain the required elements on 10/3/2012. Documentation received accounted for 154 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. November 2012 • The Agency billed 140 units of Community Access (H2021 U1) from 11/1/2012 through 11/30/2012. Documentation did not contain the required elements on 11/15, 21. Documentation received accounted for 120 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service.		

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 that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 10 of 10 individuals. Individual #1 October 2012 • The Agency billed 243 units of Adult Habilitation (T2021 U2) from 10/1/2012 through 10/31/2012. Documentation received accounted for 209 units. November 2012 • The Agency billed 282 units of Adult Habilitation (T2021 U2) from 11/1/2012 through 11/30/2012. Documentation received accounted for 254 units. December 2012 • The Agency billed 241 units of Adult Habilitation (T2021 U2) from 12/1/2012 through 12/31/2012. Documentation did not contain the required elements on 12/3, 4, 6, 18, 27, 31. Documentation received accounted for 119 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. Individual #2 October 2002 • The Agency billed 130 units of Adult Habilitation (T2021 U3) from 10/1/2012 through 10/31/2012. Documentation did not contain the required elements on 10/12, 18, 19, 24, 26. Documentation received accounted for 90 units. One or more of the following elements was not met:	**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: →	

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	➢ The signature or authenticated name of staff providing the service. November 2002 • The Agency billed 140 units of Adult Habilitation (T2021 U3) from 11/1/2012 through 11/30/2012. Documentation did not contain the required elements on 11/2, 30. Documentation received accounted for 111 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. December 2002 • The Agency billed 120 units of Adult Habilitation (T2021 U3) from 12/1/2012 through 12/31/2012. Documentation did not contain the required elements on 12/12, 14, 19, 26. Documentation received accounted for 88 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. Individual #3 October 2002 • The Agency billed 344 units of Adult Habilitation (T2021 U1) from 10/1/2012 through 10/31/2012. Documentation did not contain the required elements on 10/2, 3, 15, 22, 24, 26. Documentation received accounted for 240 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. November 2002 • The Agency billed 328 units of Adult Habilitation (T2021 U1) from 11/1/2012		

	through 11/30/2012. Documentation did not contain the required elements on 11/26, 30. Documentation received accounted for 277 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. December 2002 • The Agency billed 369 units of Adult Habilitation (T2021 U1) from 12/1/2012 through 12/31/2012. Documentation did not contain the required elements on 12/3, 5, 10, 13, 19, 20, 26, 27, 28. Documentation received accounted for 207 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. Individual #4 December 2012 • The Agency billed 222 units of Adult Habilitation (T2021 U1 U4) from 12/1/2012 through 12/31/2012. Documentation did not contain the required elements on 12/19/2012. Documentation received accounted for 176 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. Individual #5 October 2002 • The Agency billed 249 units of Adult Habilitation (T2021 U3) from 10/1/2012 through 10/31/2012. Documentation did not contain the required elements on 10/2, 5, 12, 26, 31. Documentation received accounted for 196 units. One or more of the following elements was not met: ➢ The signature or authenticated name of		

	staff providing the service. November 2002 • The Agency billed 188 units of Adult Habilitation (T2021 U3) from 11/1/2012 through 11/30/2012. Documentation did not contain the required elements on 11/30/2012. Documentation received accounted for 186 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. December 2002 • The Agency billed 157 units of Adult Habilitation (T2021 U3) from 12/1/2012 through 12/31/2012. Documentation did not contain the required elements on 12/5, 10, 13, 19, 20. Documentation received accounted for 114 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. Individual #6 October 2012 • The Agency billed 324 units of Adult Habilitation (T2021 U2) from 10/1/2012 through 10/19/2012. Documentation received accounted for 321 units. Individual #7 October 2002 • The Agency billed 128 units of Adult Habilitation (T2021 U2) from 10/1/2012 through 10/31/2012. Documentation did not contain the required elements on 10/1, 5, 10, 12, 15, 17. Documentation received accounted for 85 units. One or more of the following elements was not met:		

	➢ The signature or authenticated name of staff providing the service. November 2002 • The Agency billed 54 units of Adult Habilitation (T2021 U2) from 11/1/2012 through 11/30/2012. Documentation did not contain the required elements on 11/9, 12, 30. Documentation received accounted for 41 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. December 2002 • The Agency billed 67 units of Adult Habilitation (T2021 U2) from 12/1/2012 through 12/31/2012. Documentation did not contain the required elements on 12/14, 21, 26. Documentation received accounted for 33 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. Individual #8 October 2012 • The Agency billed 362 units of Adult Habilitation (T2021 U1) from 10/1/2012 through 10/31/2012. Documentation received accounted for 346 units. November 2012 • The Agency billed 346 units of Adult Habilitation (T2021 U1) from 11/1/2012 through 11/30/2012. Documentation did not contain the required elements on 11/15, 21. Documentation received accounted for 306 units. One or more of the following elements was not met:		

	➢ The signature or authenticated name of staff providing the service. Individual #9 November 2002 • The Agency billed 223 units of Adult Habilitation (T2021 U1) from 11/1/2012 through 11/30/2012. Documentation did not contain the required elements on 11/15, 26 28. Documentation received accounted for 190 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. December 2002 • The Agency billed 268 units of Adult Habilitation (T2021 U1) from 12/1/2012 through 12/31/2012. Documentation did not contain the required elements on 12/5, 12, 14, 26, 27. Documentation received accounted for 206 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service. Individual #10 December 2012 • The Agency billed 70 units of Adult Habilitation (T2021 U2) from 12/24/2012 through 12/31/2012. Documentation received accounted for 48 units.		

Date: June 18, 2013

To: Jyl Adair, Executive Director
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Region: Northwest
Survey Date: February 11 - 14, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Inclusion Supports (Adult Habilitation, Community Access and Supported Employment)
Survey Type: Routine

Dear Ms. Adair;

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Crystal Lopez-Beck

Crystal Lopez-Beck
Plan of Correction Coordinator
Quality Management Bureau/DHI

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