



SUSANA MARTINEZ, GOVERNOR

LYNN GALLAGHER, CABINET SECRETARY

Date: August 3, 2017

To: Cece Hunter, Executive Director
 Provider: Casa de Esperanza Inc.
 Address: 1024 S. Main Street
 State/Zip: Las Cruces, New Mexico 88005

E-mail Address: casadeesperanzainc@gmail.com

Region: Southwest & Southeast Regions
 Survey Date: April 28 – May 04, 2017
 Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012:** Living Supports - Family Living, Customized Community Supports - Individual, Customized In-Home Supports

Survey Type: Routine

Team Leader: Barbara Kane, BAS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Debbie Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Chris Melon, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Tricia Hart, AAS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau and Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Hunter;

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

Determination of Compliance:

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

Compliance with all Conditions of Participation

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

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



QMB Report of Findings – Casa de Esperanza Inc. – Southwest & Southeast Regions – April 28 – May 04, 2017

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.

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

Corrective Action:

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

On-going Quality Assurance/Quality Improvement Processes:

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

Submission of your Plan of Correction:

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

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

- 1. Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator
1170 North Solano Suite D Las Cruces, New Mexico 88001**
- 2. Developmental Disabilities Supports Division Regional Office for region of service surveyed**

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

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

Billing Deficiencies:

If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a Void/Adjust claims or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

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

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

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

Please be advised that there is a one-week lag period for applying payments received by check to Voided/Adjusted claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

Request for Informal Reconsideration of Findings (IRF):

If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

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

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

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

Sincerely,

Barbara Kane, BAS

Barbara Kane, BAS
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	April 28, 2017
Entrance Conference Date:	May 01, 2017
Present:	<u>Casa de Esperanza Inc.</u> Kiley Gifford, General Manager Kenneth Hunter, Co-Owner <u>DOH/DHI/QMB</u> Barbara Kane, BAS, Healthcare Surveyor Chris Melon, MPA, Healthcare Surveyor
Exit Conference Date:	May 04, 2017
Present:	<u>Casa de Esperanza Inc.</u> Aaron Gifford, Service Coordinator / Incident Management Coordinator Kiley Gifford, General Manager <u>DOH/DHI/QMB</u> Debbie Russell, BS, Healthcare Surveyor Barbara Kane, BAS, Healthcare Surveyor Chris Melon, MPA, Healthcare Surveyor Lora Norby, Healthcare Surveyor <u>DDSD Southeast & Southwest Regional Office</u> Jeana Caruthers, SW Regional Director Michelle Lyon, SE Regional Director (via phone)
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 17 0 - Jackson Class Members 17 - Non-Jackson Class Members 9 - Customized Community Supports - Individual 6 - Customized In-Home Supports 11 - Living Supports - Family Living
Total Homes Visited	Number: 11
❖ Family Living Homes Visited	Number: 11
Persons Served Records Reviewed	Number: 17
Persons Served Interviewed	Number: 6
Persons Served Observed	Number: 7 (7 individuals chose not to participate in the interview process)
Persons Served Not Seen and/or Not Available	Number: 4

Direct Support Personnel Interviewed	Number:	24 (One Substitute Care Provider interviewed as a DSP)
Direct Support Personnel Records Reviewed	Number:	67 (One Service Coordinator also performs role as DSP)
Substitute Care/Respite Personnel Records Reviewed	Number:	30
Service Coordinator Records Reviewed	Number:	4 (One Service Coordinator also performs role as DSP)
Administrative Interviews	Number:	2 (One Service Coordinator also performs role as Incident Management Coordinator)

Administrative Processes and Records Reviewed:

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

CC: Distribution List: DOH - Division of Health Improvement
 DOH - Developmental Disabilities Supports Division
 DOH - Office of Internal Audit
 HSD - Medical Assistance Division
 MFEAD – NM Attorney General

Attachment A

Provider Instructions for Completing the QMB Plan of Correction (POC) Process

Introduction:

After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued deficiencies and non-compliance.

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

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

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

Instructions for Completing Agency POC:

Required Content

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

The Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and

- sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

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

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

POC Document Submission Requirements

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

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

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

Attachment B

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

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Management system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified in the QMB Report of Findings. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

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

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in the following Service Domains.

Case Management Services (Four Service Domains):

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

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

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

Conditions of Participation (CoPs)

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

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP (See the next section for a list of CoPs). The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for

significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

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

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

Service Domain: Plan of Care ISP Development & Monitoring

Condition of Participation:

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

Condition of Participation:

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

Service Domain: Level of Care

Condition of Participation:

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

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

Service Domain: Qualified Providers

Condition of Participation:

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

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

Service Domain: Service Plan: ISP Implementation

Condition of Participation:

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

Service Domain: Health, Welfare and Safety

Condition of Participation:

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

Condition of Participation:

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

QMB Determinations of Compliance

Compliance with Conditions of Participation

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

Partial-Compliance with Conditions of Participation

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

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

Non-Compliance with Conditions of Participation

The QMB determination of *Non-Compliance with Conditions of Participation* indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains and/or 6 or more Condition of Participation level deficiencies overall, as well as widespread Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

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

Attachment C

Guidelines for the Provider

QMB Report of Findings – Casa de Esperanza Inc. – Southwest & Southeast Regions – April 28 – May 04, 2017

Survey Report #: Q.17.4.DDW.26584867.3/4.RTN.01.17.215

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 IRF process, email the IRF Chairperson, Crystal Lopez-Beck at Crystal.Lopez-Beck@state.nm.us for assistance.

The following limitations apply to the IRF process:

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

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

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

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

Agency: Casa de Esperanza Inc. - Southwest & Southeast Regions
Program: Developmental Disabilities Waiver
Service: 2012: Living Supports - Family Living, Customized Community Supports - Individual, Customized In-Home Supports
Monitoring Type: Routine Survey
Survey Date: April 28 – May 04, 2017

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Service Plans: ISP Implementation - Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.			
Tag # 1A08 Agency Case File	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p>Chapter 5 (CIES) 3. Agency Requirements J. Consumer Records Policy: Community Integrated Employment Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p>Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. Additional documentation that is required to be maintained at the administrative office includes:</p> <ol style="list-style-type: none"> Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD. <p>Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are</p>	<p>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 17 Individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> Positive Behavioral Support Plan <ul style="list-style-type: none"> Not Found (#10) Behavior Crisis Intervention Plan <ul style="list-style-type: none"> Not Found (#10) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

<p>required to comply with the DDSD Individual Case File Matrix policy.</p> <p>Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p>Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p>Chapter 13 (IMLS) 2. Service Requirements: C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items)</p> <ul style="list-style-type: none"> • Emergency contact information; • Personal identification; • ISP budget forms and budget prior authorization; • ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan (PBSP), Behavior Crisis Intervention Plan (BCIP), or other relevant behavioral plans, Medical Emergency Response Plan (MERP), Healthcare Plan, Comprehensive Aspiration Risk Management Plan (CARMP), and Written Direct Support Instructions (WDSI); • Dated and signed evidence that the individual has been informed of agency grievance/complaint procedure at least 			
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<p>annually, or upon admission for a short term stay;</p> <ul style="list-style-type: none"> • Copy of Guardianship or Power of Attorney documents as applicable; • Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays; • Written consent by relevant health decision maker and primary care practitioner for self-administration of medication or assistance with medication from DSP as applicable; • Progress notes written by DSP and nurses; • Signed secondary freedom of choice form; • Transition Plan as applicable for change of provider in past twelve (12) months. <p>DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director’s Release: Consumer Record Requirements eff. 11/1/2012</p> <p>III. Requirement Amendments(s) or Clarifications:</p> <p>A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director’s release.</p> <p>H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.</p> <p>NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.</p>			
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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 # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	Standard Level Deficiency		
<p>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.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 17 individuals.</p> <p>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Administrative Files Reviewed:</p> <p>Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes</p> <p>Individual #4</p> <ul style="list-style-type: none"> • According to the Live Outcome; Action Step for "...will plan and shop for dinner" is to be completed 1 time per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2017. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	<p> </p>

Tag # LS14 / 6L14 Residential Case File	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p>CHAPTER 11 (FL) 3. Agency Requirements C. Residence Case File: The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDS Individual Case File Matrix policy.</p> <p>CHAPTER 12 (SL) 3. Agency Requirements C. Residence Case File: The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDS Individual Case File Matrix policy.</p> <p>CHAPTER 13 (IMLS) 2. Service Requirements B.1. Documents to Be Maintained in The Home:</p> <ol style="list-style-type: none"> Current Health Passport generated through the e-CHAT section of the Therap website and printed for use in the home in case of disruption in internet access; Personal identification; Current ISP with all applicable assessments, teaching and support strategies, and as applicable for the consumer, PBSP, BCIP, MERP, health care plans, CARMPs, Written Therapy Support Plans, and any other plans (e.g. PRN Psychotropic Medication Plans) as applicable; Dated and signed consent to release information forms as applicable; Current orders from health care practitioners; Documentation and maintenance of accurate medical history in Therap website; Medication Administration Records for the current month; Record of medical and dental appointments for the current year, or during the period of stay for short term stays, including any treatment provided; 	<p>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 8 of 11 Individuals receiving Family Living Services.</p> <p>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Annual ISP: <ul style="list-style-type: none"> ◦ Not current (#7) • Individual Specific Training Section of ISP (formerly Addendum B): <ul style="list-style-type: none"> ◦ Not current (#7) • ISP Teaching and Supports Strategies <ul style="list-style-type: none"> ◦ <i>Individual #3 - TSS not found for the following Action Steps:</i> <ul style="list-style-type: none"> ◦ Live Outcome Statement <ul style="list-style-type: none"> ➤ "...will choose which ADL to assist in." ◦ <i>Individual #8 - TSS not found for the following Action Steps:</i> <ul style="list-style-type: none"> ◦ Live Outcome Statement <ul style="list-style-type: none"> ➤ "...buys needed materials to build his gardening plot." ➤ "...maintains his garden." ◦ Develop Relationships/ Have Fun Outcome Statement Outcome Statement <ul style="list-style-type: none"> ➤ " With assistance...finds a facility for horse riding lessons." ➤ "...tracks his lessons with his phone and attends lessons as scheduled." ◦ <i>Individual #10 - TSS not found for the following Action Steps:</i> 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (<i>What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

<p>i. Progress notes written by DSP and nurses; j. Documentation and data collection related to ISP implementation; k. Medicaid card; l. Salud membership card or Medicare card as applicable; and m. A Do Not Resuscitate (DNR) document and/or Advanced Directives as applicable.</p> <p>DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications: A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.</p> <p>H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.</p> <p><i>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</i> CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual;</p>	<ul style="list-style-type: none"> ◦ Live Outcome Statement <ul style="list-style-type: none"> ➢ "...will pay the bill." • Positive Behavioral Plan <ul style="list-style-type: none"> ◦ Not found (#15) • Behavior Crisis Intervention Plan <ul style="list-style-type: none"> ◦ Not found (#10) • Speech Therapy Plan <ul style="list-style-type: none"> ◦ Not found (#1, 2, 7) • Occupational Therapy Plan <ul style="list-style-type: none"> ◦ Not found (#1) • Healthcare Passport <ul style="list-style-type: none"> ◦ Not found (#3, 8, 11) <p>Progress Notes/Daily Contacts Logs:</p> <ul style="list-style-type: none"> ◦ Individual #1 – None found for 5/1/2017. ◦ Individual #2 – None found for 5/1 – 3, 2017. ◦ Individual #7 – None found for 5/1 – 2, 2017. ◦ Individual #11 – None found for 5/1/2017. 		
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<p>(2) Complete and current Health Assessment Tool;</p> <p>(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</p> <p>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> (a) The name of the individual; (b) A transcription of the healthcare practitioner's prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. 			
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<p>(h) For PRN medication an explanation for the use of the PRN must include:</p> <ul style="list-style-type: none"> (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. <p>(i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis.</p> <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and</p> <p>(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.</p>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Qualified Providers - The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.			
Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency		
<p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p> <p>D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.</p> <p>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</p> <p>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</p> <p>G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.</p>	<p>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 1 of 67 Direct Support Personnel.</p> <p>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed as required:</p> <ul style="list-style-type: none"> • CPR <ul style="list-style-type: none"> ◦ Not Found (DSP #519) • First Aid <ul style="list-style-type: none"> ◦ Not Found (DSP #519) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (<i>What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): → </p>	<p> </p>

<p>H. Staff shall complete and maintain certification in a DDS-approved medication course in accordance with the DDS Medication Delivery Policy M-001.</p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p>CHAPTER 5 (CIES) 3. Agency Requirements</p> <p>G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDS policy T-003: Training Requirements for Direct Service Agency Staff Policy.</p> <p>CHAPTER 6 (CCS) 3. Agency Requirements</p> <p>F. Meet all training requirements as follows:</p> <p>1. All Customized Community Supports Providers shall provide staff training in accordance with the DDS Policy T-003: Training Requirements for Direct Service Agency Staff Policy;</p> <p>CHAPTER 7 (CIHS) 3. Agency Requirements</p> <p>C. Training Requirements: The Provider Agency must report required personnel training status to the DDS Statewide Training Database as specified in the DDS Policy T-001: Reporting and Documentation of DDS Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDS Policy T-003: Training Requirements for Direct Service Agency Staff Policy</p> <p>CHAPTER 11 (FL) 3. Agency Requirements</p> <p>B. Living Supports- Family Living Services</p>			
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Provider Agency Staffing Requirements: 3. Training:

A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDS Statewide Training Database as specified in DDS Policy T-001: Reporting and Documentation for DDS Training Requirements.

**CHAPTER 12 (SL) 3. Agency Requirements
B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:**

A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDS Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDS Statewide Training Database as specified in DDS Policy T-001: Reporting and Documentation for DDS Training Requirements.

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;

Tag # 1A25 Criminal Caregiver History Screening	Standard Level Deficiency		
<p>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</p> <p>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. (1) In cases where the criminal history record lists an arrest for a crime that would constitute a disqualifying conviction and no final disposition is listed for the arrest, the department will attempt to notify the applicant, caregiver or hospital caregiver and request information from the applicant, caregiver or hospital caregiver within timelines set forth in the department's notice regarding the final disposition of the arrest. Information requested by the department may be evidence, for example, a certified copy of an acquittal, dismissal or conviction of a lesser included crime. (2) An applicant's, caregiver's or hospital caregiver's failure to respond within the required timelines regarding the final disposition of the arrest for a crime that would constitute a</p>	<p>Based on record review, the Agency did not maintain documentation indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 3 of 100 Agency Personnel.</p> <p>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</p> <p>Service Coordination Personnel (SC):</p> <ul style="list-style-type: none"> • #521 – Date of hire 9/09/2016. <p>Substitute Care/Respite Personnel:</p> <ul style="list-style-type: none"> • #578 – Date of hire 12/10/2013. <p>The following Agency Personnel Files contained Caregiver Criminal History Screenings, which were not specific to the Agency:</p> <p>Substitute Care/Respite Personnel:</p> <ul style="list-style-type: none"> • #561 – Date of hire 12/1/2013. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (<i>What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	<p> </p>

disqualifying conviction shall result in the applicant's, caregiver's or hospital caregiver's temporary disqualification from employment as a caregiver or hospital caregiver pending written documentation submitted to the department evidencing the final disposition of the arrest. Information submitted to the department may be evidence, for example, of the certified copy of an acquittal, dismissal or conviction of a lesser included crime. In instances where the applicant, caregiver or hospital caregiver has failed to respond within the required timelines the department shall provide notice by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A., of Section 7.1.9.9.

(3) The department will not make a final determination for an applicant, caregiver or hospital caregiver with a pending potentially disqualifying conviction for which no final disposition has been made. In instances of a pending potentially disqualifying conviction for which no final disposition has been made, the department shall notify the care provider, applicant, caregiver or hospital caregiver by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A, of Section 7.1.9.9.

B. Employment Pending Reconsideration Determination: At the discretion of the care provider, an applicant, caregiver or hospital caregiver whose nationwide criminal history record reflects a disqualifying conviction and who has requested administrative reconsideration may continue conditional supervised employment pending a determination on reconsideration.

NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or

<p>hospital caregiver from employment or contractual services with a care provider:</p> <p>A. homicide;</p> <p>B. trafficking, or trafficking in controlled substances;</p> <p>C. kidnapping, false imprisonment, aggravated assault or aggravated battery;</p> <p>D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;</p> <p>E. crimes involving adult abuse, neglect or financial exploitation;</p> <p>F. crimes involving child abuse or neglect;</p> <p>G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</p> <p>H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p>			
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Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	Standard Level Deficiency		
<p>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.</p> <p>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.</p> <p>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.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the</p>	<p>Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 100 Agency Personnel.</p> <p>The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:</p> <p>Service Coordination Personnel (SC):</p> <ul style="list-style-type: none"> • #521 – Date of hire 9/09/2016. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (<i>What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): → </p>	<p> </p>

<p>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.</p> <p>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.</p> <p>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.</p>			
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Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency		
<p>NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS</p> <p>NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner.</p> <p>B. Training curriculum: Prior to an employee or volunteer’s initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider’s facility. Training shall be conducted in a language that is understood by the employee or volunteer.</p> <p>C. Incident management system training curriculum requirements:</p> <p>(1) The community-based service provider shall conduct training or designate a knowledgeable representative to conduct</p>	<p>Based on record review, the Agency did not ensure Incident Management Training for 1 of 70 Agency Personnel.</p> <p>Direct Support Personnel (DSP):</p> <ul style="list-style-type: none"> Incident Management Training (Abuse, Neglect and Exploitation) (DSP #568) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> → </p>	<p> </p>

<p>training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to:</p> <ul style="list-style-type: none"> (a) an overview of the potential risk of abuse, neglect, or exploitation; (b) informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; (c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths; (d) specific instructions on how to respond to abuse, neglect, or exploitation; (e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. <p>(2) All current employees and volunteers shall receive training within 90 days of the effective date of this rule.</p> <p>(3) All new employees and volunteers shall receive training prior to providing services to consumers.</p> <p>D. Training documentation: All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation</p>			
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shall subject the community-based service provider to the penalties provided for in this rule.

Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 II. POLICY STATEMENTS:

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

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Health and Welfare - The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.			
Tag # 1A08.2 Healthcare Requirements	Standard Level Deficiency		
<p>NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.</p> <p>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.</p> <p>DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications:</p> <p>A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.</p> <p>H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p>	<p>Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 2 of 17 individuals receiving Community Inclusion, Living Services and Other Services.</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current</p> <p>Community Living Services / Community Inclusion Services (Individuals Receiving Multiple Services):</p> <ul style="list-style-type: none"> • Dental Exam <ul style="list-style-type: none"> ◦ Individual #1 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #7 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

<p>Chapter 5 (CIES) 3. Agency Requirements H. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy.</p> <p>Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p>Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p>Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p>Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p>Chapter 13 (IMLS) 2. Service Requirements:</p>			
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C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items)...

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007

CHAPTER 1 II. PROVIDER AGENCY

REQUIREMENTS: D. Provider Agency Case File for the Individual:

All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:

- (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;

CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING

G. Health Care Requirements for Community Living Services.

(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the

<p>DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first.</p> <p>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <ul style="list-style-type: none"> (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p>			
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<p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <ul style="list-style-type: none"> (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine). 			
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Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p>CHAPTER 11 (FL) Living Supports – Family Living Agency Requirements G. Residence Requirements for Living Supports- Family Living Services: 1. Family Living Services providers must assure that each individual's residence is maintained to be clean, safe and comfortable and accommodates the individuals' daily living, social and leisure activities. In addition, the residence must:</p> <p>a. Maintain basic utilities, i.e., gas, power, water and telephone;</p> <p>b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;</p> <p>c. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system;</p> <p>d. Have a general-purpose first aid kit;</p> <p>e. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;</p> <p>f. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year;</p>	<p>Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 7 of 11 Family Living residences.</p> <p>Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:</p> <p>Family Living Requirements:</p> <ul style="list-style-type: none"> • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#1, 2, 3, 7, 10, 15) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#10, 13, 15) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 7, 15) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> → </p>	<p> </p>

<p>g. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and</p> <p>h. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.</p> <p>CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports- Supported Living Services: 1. Supported Living Provider Agencies must assure that each individual's residence is maintained to be clean, safe, and comfortable and accommodates the individual's daily living, social, and leisure activities. In addition, the residence must:</p> <p>a. Maintain basic utilities, i.e., gas, power, water, and telephone;</p> <p>b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;</p> <p>c. Ensure water temperature in home does not exceed safe temperature (110° F);</p>			
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- d. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system;
- e. Have a general-purpose First Aid kit;
- f. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;
- g. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills must occur at least once a year during each shift;
- h. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and
- i. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.

**CHAPTER 13 (IMLS) 2. Service Requirements
R. Staff Qualifications: 3. Supervisor Qualifications And Requirements:**

S Each residence shall include operable safety equipment, including but not limited to, an operable smoke detector or sprinkler system, a carbon monoxide detector if any natural gas appliance or heating is used, fire extinguisher, general purpose first aid kit,

<p>written procedures for emergency evacuation due to fire or other emergency and documentation of evacuation drills occurring at least annually during each shift, phone number for poison control within line of site of the telephone, basic utilities, general household appliances, kitchen and dining utensils, adequate food and drink for three meals per day, proper food storage, and cleaning supplies.</p> <p>T Each residence shall have a blood borne pathogens kit as applicable to the residents' health status, personal protection equipment, and any ordered or required medical supplies shall also be available in the home.</p> <p>U If not medically contraindicated, and with mutual consent, up to two (2) individuals may share a single bedroom. Each individual shall have their own bed. All bedrooms shall have doors that may be closed for privacy. Individuals have the right to decorate their bedroom in a style of their choosing consistent with safe and sanitary living conditions.</p> <p>V For residences with more than two (2) residents, there shall be at least two (2) bathrooms. Toilets, tubs/showers used by the individuals shall provide for privacy and be designed or adapted for the safe provision of personal care. Water temperature shall be maintained at a safe level to prevent injury and ensure comfort and shall not exceed one hundred ten (110) degrees.</p>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Medicaid Billing/Reimbursement - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.			
Tag # IH32 Customized In-Home Supports Reimbursement	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p>CHAPTER 7 (CIHS) 4. REIMBURSEMENT. A.</p> <p>A. All Provider Agencies must maintain all records necessary to fully disclose the service, quality, and quantity provided to individuals. The Provider Agency records shall be sufficiently detailed to substantiate the individual's name, date, time, Provider Agency name, nature of services and length of a session of service billed. Providers are required to comply with the Human Services Department Billing Regulations.</p> <p>1. The maximum allowable billable hours cannot exceed the budget allocation in the associated base budget.</p> <p>II. Billable Units: The billable unit for Customized In-Home Support is based on a fifteen (15) minute unit.</p> <p>1. Customized In-Home Supports has two separate procedures codes with the equivalent reimbursed amount.</p> <p>a. Living independently; and</p> <p>b. Living with family and/or natural supports:</p> <p>i. The living with family and/or natural supports rate category must be used when the individual is living with paid or</p>	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized In-Home Supports Reimbursement for 1 of 6 individuals.</p> <p>Individual #6 March 2017</p> <ul style="list-style-type: none"> The Agency billed 52 units of Customized In-Home Supports (S5125 HB) on 3/14/2017. Documentation received accounted for 48 units. <i>(Note: Void/Adjust Claim provided during the on-site survey. Provider please complete POC for ongoing QA/QI.)</i> 	<p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> → </p>	<p> </p>

unpaid family members.

III. Billable Activities:

1. Direct care provided to an individual in the individual's residence, consistent with the Scope of Services, any portion of the day.
2. Direct support provided to an individual consistent with the Scope of Services by Customized In-Home Supports direct support personnel in community locations other than the individual's residence.

NMAC 8.302.1.17 Effective Date 9-15-08

Record Keeping and Documentation

Requirements - A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

Detail Required in Records - Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed, diagnosis and medical necessity of any service . . . Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.

Services Billed by Units of Time -

Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.

Records Retention - A provider who receives payment for treatment, services or goods must retain all medical and business records relating

to any of the following for a period of at least six years from the payment date:

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

Date: September 26, 2017

To: Cece Hunter, Executive Director
Provider: Casa de Esperanza Inc.
Address: 1024 S. Main Street
State/Zip: Las Cruces, New Mexico 88005

E-mail Address: casadeesperanzainc@gmail.com

Region: Southwest & Southeast Regions
Survey Date: April 28 – May 04, 2017
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012:** Living Supports - Family Living, Customized Community Supports - Individual, Customized In-Home Supports

Survey Type: Routine

Dear Ms. Hunter;

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.17.4.DDW.26584867.3/4.RTN.09.17.269