Modified by IRF 7/27/2018 & Scoring Modified as result of Pilot 1 9/12/2018

Date:	June 13, 2018
To:	Angelique Tafoya, Executive Director
Provider:	Alta Mira Specialized Family Services, Inc.
Address:	1605 Carlisle Blvd NE
State/Zip:	Albuquerque, New Mexico 87110
E-mail Address:	ATafoya@AltaMiraNM.org
CC: Board Chair E-Mail Address	Brett Penfold, Board President sbjavaman41@aol.com
Region:	Metro
Survey Date:	April 6 – 13, 2018
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2012:*** Family Living, Customized Community Supports and Customized In-Home Supports
Survey Type:	Routine
Team Leader:	Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Kandis Gomez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Monica Valdez, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Nick Gomez, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Anthony Fragua, BFA, Program Manager, Division of Health Improvement/Quality Management Bureau; Michelle Beck, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Tafoya;

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

Determination of Compliance:

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

Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags: This determination is based on noncompliance the following. Your agency was cited with Condition of Participation level deficiencies and Standard level deficiencies *(refer to Attachment B for details)*. You are required to complete and implement a Plan of Correction in the attached QMB Report of Findings:

The following tags are identified as Condition of Participation Level Deficiencies:

- Tag # 1A32 - Administrative Case File: Individual Service Plan Implementation
- Tag # LS14 - Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # 1A08.2 - Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A05 - General Requirements / Agency Policy and Procedure Requirements
- Tag # 1A31 - Client Rights/Human Rights

The following tags are identified as Standard Level Deficiencies:

- Tag # 1A08.3 - Administrative Case File: Individual Service Plan / ISP Components
- Tag # 1A08.1 - Administrative and Residential Case File: Progress Notes
- Tag # 1A32.1 - Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*
- Tag # 1A32.2 - Individual Service Plan Implementation (Residential Implementation)
- Tag # 1A38.1 - Living Care Arrangement / Community Inclusion Reporting Requirements (Reporting Components)
- Tag # 1A20 - Direct Support Personnel Training
- Tag # 1A22 - Agency Personnel Competency
- Tag # 1A43.1 - General Events Reporting: Individual Reporting
- Tag # 1A15.2 - Administrative Case File: Healthcare Documentation (Therap and Required Plans)
- Tag # 1A27.2 - Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider
- Tag # LS25 - Residential Health & Safety (Supported Living, Family Living, IMLS)
- Tag # LS27 - Family Living Reimbursement

Plan of Correction:

The attached Report of Findings identifies the deficiencies found during your agency's on-site 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.

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (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 for Current Citation:

- 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 on an ongoing basis? (i.e. file reviews, 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 within your agency)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction in the available space on the two right-hand 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" claim 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 Void/Adjust 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:

Request for Informal Reconsideration of Findings
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request/QMB

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,

Deb Russell

Deb Russell, BS
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	April 6, 2018
Contact:	**Alta Mira Specialized Family Services, Inc.** Angelique Tafoya, Executive Director **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	April 9, 2019
Present:	**Alta Mira Specialized Family Services, Inc.** Angelique Tafoya, Executive Director Kari Jo Miller, Family Support Services Director **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor Lora Norby, Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Michelle Beck, Healthcare Surveyor Nick Gomez, BS, Healthcare Surveyor
Exit Conference Date:	April 13, 2018
Present:	**Alta Mira Specialized Family Services, Inc.** Angelique Tafoya, Executive Director Kari Jo Miller, Family Support Services Director Ryan Bobbe, Service Coordinator Melissa Cawasco, Respite Service Coordinator Nancy Hunt, Administrative Manager Malia Buhl, Service Coordinator Tai Benally, Service Coordinator Julie Brinkley, Clinical Manager - Nursing Joe Murphy, Respite Service Coordinator Chris Griffin, Service Coordinator **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor Kandis Gomez, AA, Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Michelle Beck, Healthcare Surveyor Anthony Fragua, BFA, Health Program Manager **DDSD - Metro Regional Office** Linda Clark, Assistant Regional Director
Administrative Locations Visited:	1
Total Sample Size:	18 0 - *Jackson* Class Members 18 - Non-*Jackson* Class Members 15 - Family Living 3 - Customized In-Home Supports 1 - Customized Community Supports

Total Homes Visited	15
❖ Family Living Homes Visited	15
Persons Served Records Reviewed	18
Persons Served Interviewed	11
Persons Served Observed	4 (4 Individuals chose not to participate)
Persons Served Not Seen and/or Not Available	3 (3 Individuals were not available during the on-site survey)
Direct Support Personnel Records Reviewed	148
Direct Support Personnel Interviewed	17
Substitute Care/Respite Personnel Records Reviewed	248
Service Coordinator Records Reviewed	10
Administrative Interviews	1

Administrative Processes and Records Reviewed:

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

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

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 DDSD Regional Office for purposes of contract management or 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 cited to prevent recurrence and information that ensures the regulation cited comes into and remains in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance (QA) Plan.

If a deficiency has already been corrected since the on-site survey, 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 following details should be considered when developing your Plan of Correction:

The Plan of Correction must address each deficiency cited in the Report of Findings unless otherwise noted with a "No Plan of Correction Required statement." The Plan of Correction must address the five (5) areas listed below:

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 those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented, and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective actions 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 Individual Served, agency personnel and administrative and service delivery site 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 to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (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 documents containing HIPAA Protected Health Information (PHI) documents must be submitted through S-Comm (Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may 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 other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation) ; 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 Assurance 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 during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. 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.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

Service Domains and CoPs for <u>Living Care Arrangements and Community Inclusion</u> are as follows:

<u>Service Domain: Service Plan: ISP Implementation -</u> *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.3 –** Administrative Case File: Individual Service Plan / ISP Components
- **1A32 –** Administrative Case File: Individual Service Plan Implementation
- **LS14 –** Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- **IS14 –** CCS / CIES Service Delivery Site Case File (ISP and Healthcare Requirements)

<u>Service Domain: Qualified Providers -</u> *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.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A20 -** Direct Support Personnel Training
- **1A22 -** Agency Personnel Competency

- **1A37 –** Individual Specific Training

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):
- **1A25.1 –** Caregiver Criminal History Screening
- **1A26.1 –** Consolidated On-line Registry Employee Abuse Registry

Service Domain: Health, Welfare and Safety - *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.*

Potential Condition of Participation Level Tags, if compliance is below 85%:
- **1A08.2 –** Administrative Case File: Healthcare Requirements & Follow-up
- **1A09 –** Medication Delivery Routine Medication Administration
- **1A09.1 –** Medication Delivery PRN Medication Administration
- **1A15.2 –** Administrative Case File: Healthcare Documentation (Therap and Required Plans)

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):
- **1A05 –** General Requirements / Agency Policy and Procedure Requirements
- **1A07 –** Social Security Income (SSI) Payments
- **1A09.2 –** Medication Delivery Nurse Approval for PRN Medication
- **1A15 –** Healthcare Documentation - Nurse Availability
- **1A31 –** Client Rights/Human Rights
- **LS25.1 –** Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

QMB Determinations of Compliance (see Attachment D grid below for specifics)

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. 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*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

Partial-Compliance with Standard Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags* indicates that a provider is in compliance with all Condition of Participation Level deficiencies but is out of compliance with a certain percentage of Standard Level deficiencies. This partial-compliance, if not corrected, may result in a negative outcome or the potential for more than minimal harm to individuals' health and safety. There are two ways to receive a determination of Partial Compliance with Standard Level Tags:

1. Your Report of Findings includes 14 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected.

2. Your Report of Findings includes 15 or more Standard Level Tags with between 50% to 74% of the survey sample affected.

Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags with less than 75% of the survey sample affected. 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.

Non-Compliance:

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. 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. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 15 or more Standard Level Tags with 75% to 100% of the survey sample affected.

2. Your Report of Findings includes any amount of Standard Level Tags with one to five (1 – 5) Condition of Participation Level Tags and 75 to 100% of the survey sample affected.

3. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Attachment C

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

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

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

Compliance Determination	Attachment D: Weighting							
	LOW		MEDIUM			HIGH		
Standard Level Tags:	up to 14	15 or more	up to 14	15 or more	Any Amount	15 or more	Any Amount	Any Amount
	and	and	and	and	And/or	and	And/or	And/or
COP Level Tags:	0 COP	0 COP	0 COP	0 COP	1 to 5 COP	0 CoPs	1 to 5 CoP	6 or more COP
	and	and	and	and	and	and	and	and
Sample Effected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%	0 to 74%	75 to 100%	75 to 100%	Any Amount
"Non-Compliance"						**15 or more** Standard Level tags with **75 to 100%** of Individuals in the sample cited throughout the report	**Any Amount** Standard Level deficiencies and **1 to 5** Conditions of Participation Level Deficiencies with 75 to 100% cited throughout the report.	**Any Amount** Standard Level deficiencies and **6 or more** Conditions of Participation Level Deficiencies.
"Partial Compliance with Standard Level tags and Condition of Participation Level Tags"					**Any Amount of** Standard level tags, plus **1 to 5** Conditions of Participation Level tags, with **0 to 74%** of individuals in the sample cited throughout the report of findings.			
"Partial Compliance with Standard Level tags"			**up to 14** Standard Level tags with **75 to 100%** of individuals in the sample cited throughout the report of findings.	**15 or more** Standard Level tags with **50 to 74%** individuals in the sample cited throughout the report of findings.				
"Compliance"	**Up to 14** Standard level tags **0 to 74%** of individuals in the sample cited throughout the report of findings	**15 or more** Standard Level tags with **0 to 49%** of individuals in the sample cited throughout the report of findings.						

Agency: **Alta Mira Specialized Family Services – Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** Family Living, Customized Community Supports, Customized In-Home Supports
Survey Type: Routine
Survey Date: **April 6 – 13, 2018**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Due Date
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 # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components ***(Upheld by IRF)***	**Standard Level Deficiency** *(Modified as result of Pilot 1)*		
NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY. **NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS.** **NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.** Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 6 Individual Service Plan:** The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP. **6.5.2 ISP Revisions:** The ISP is a dynamic document that changes with the person's desires, circumstances, and need. IDT members must collaborate and request an IDT meeting from the CM when a need to modify the ISP arises. The CM convenes the IDT within ten days of receipt of any reasonable request to	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 18 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Teaching and Support Strategies:** • *Individual #18 - TSS not found for the following Work Outcome Statement / Action Steps:* "…will complete his assigned volunteer duties" *Notes: Finding for Individual #18 upheld by IRF 7/27/2018.*	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

convene the team, either in person or through teleconference. **6.6 DDSD ISP Template:** The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e. an acknowledgement of receipt of specific information) and other elements depending on the age of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use in order to better demonstrate required elements of the PCP process and ISP development. The ISP is completed by the CM with the IDT input and must be completed according to the following requirements: 1. DD Waiver Provider Agencies should not recommend service type, frequency, and amount (except for required case management services) on an individual budget prior to the Vision Statement and Desired Outcomes being developed. 2. The person does not require IDT agreement/approval regarding his/her dreams, aspirations, and desired long-term outcomes. 3. When there is disagreement, the IDT is required to plan and resolve conflicts in a manner that promotes health, safety, and quality of life through consensus. Consensus means a state of general agreement that allows members to support the proposal, at least on a trial basis. 4. A signature page and/or documentation of participation by phone must be completed. 5. The CM must review a current Addendum			

A and DHI ANE letter with the person and Court appointed guardian or parents of a minor, if applicable. **6.6.3 Additional Requirements for Adults:** Because children have access to other funding sources, a larger array of services are available to adults than to children through the DD Waiver. (See Chapter 7: Available Services and Individual Budget Development). The ISP Template for adults is also more extensive, including Action Plans, Teaching and Support Strategies (TSS), Written Direct Support Instructions (WDSI), and Individual Specific Training (IST) requirements. **6.6.3.1. Action Plan:** Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes. Multiple service types may be included in the Action Plan under a single Desired Outcome. Multiple Provider Agencies can and should be contributing to Action Plans toward each Desired Outcome. 1. Action Plans include actions the person will take; not just actions the staff will take. 2. Action Plans delineate which activities will be completed within one year. 3. Action Plans are completed through IDT consensus during the ISP meeting. 4. Action Plans must indicate under "Responsible Party" which DSP or service provider (i.e. Family Living, CCS, etc.) are responsible for carrying out the Action Step. **6.6.3.2 Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI):** After the ISP meeting, IDT members conduct a task analysis and assessments necessary to create effective TSS and WDSI to support those Action Plans that			

require this extra detail. All TSS and WDSI should support the person in achieving his/her Vision. **6.6.3.3 Individual Specific Training in the ISP:** The CM, with input from each DD Waiver Provider Agency at the annual ISP meeting, completes the IST requirements section of the ISP form listing all training needs specific to the individual. Provider Agencies bring their proposed IST to the annual meeting. The IDT must reach a consensus about who needs to be trained, at what level (awareness, knowledge or skill), and within what timeframe. (See Chapter 17.10 Individual-Specific Training for more information about IST.) **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records** **20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create			

and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **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. **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. **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.			

Tag # 1A08.1 Administrative and Residential Case File: Progress Notes *(Modified by IRF)*	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 20: Provider Documentation and Client Records** **20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 4 of 18 Individuals. Review of the Agency individual case files revealed the following items were not found: **Administrative Case File:** **Family Living Progress Notes/Daily Contact Logs** • Individual #9 - None found for 1/31/2018. *Note: Finding for Individual #9 removed by IRF 7/27/2018.* • Individual #10 - None found for 1/8, 18 and 23, 2018. **Residential Case File:** **Family Living Progress Notes/Daily Contact Logs** • Individual #2 - None found for 4/1 – 8, 2018. *(Home visit 4/9/2018)* • Individual #7 - None found for 4/10/2018. *(Home visit 4/11/2018)* • Individual #9 - None found for 4/7 – 10, 2018. *(Home visit 4/11/2018)*	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **Chapter 6 (CCS) 3. Agency Requirements: 4. Reimbursement A. Record Requirements 1.** …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 7 (CIHS) 3. Agency Requirements: 4. Reimbursement A. 1.**…Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 11 (FL) 3. Agency Requirements: 4. Reimbursement A. 1.**…Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record…			

Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	Condition of Participation Level Deficiency *(Upheld as result of Pilot 1)*		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on administrative 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 6 of 18 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #3 • None found regarding: Live Outcome/Action Step: "…will diet and will participate in exercise activity" for 12/2017 – 2/2018. Action step is to be completed 1 time per day. • None found regarding: Fun Outcome/Action Step: "…will decide on outing or activities with his family" for 12/2017 – 2/2018. Action step is to be completed 3 times per week. Individual #9 • None found regarding: Fun Outcome/Action Step: "…will choose plan and participate in activities" for 3/2018. Action step is to be completed 2 times per month.	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 6: Individual Service Plan (ISP)** **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records** **20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.	Individual #17 • None found regarding: Fun Outcome/Action Step: "…will choose what activity she would like to do" for 12/2017 – 2/2018. Action step is to be completed 3 times per month. • None found regarding: Fun Outcome/Action Step: "…will participate in the activity" for 12/2017 – 2/2018. Action step is to be completed 3 times per month. Individual #18 • None found regarding: Live Outcome/Action Step: "…FLP will assist … in choosing what pants to wear" for 1/2018 – 3/2018. Action step is to be completed 5 times per week. **Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #8 • None found regarding: Live Outcome/Action Step: "…will practice telling time on analog clock" for 1/2018. Action step is to be completed 3 times per week. • None found regarding: Live Outcome/Action Step: "…will go over food options and identify how much things cost" for 1/2018. Action step is to be completed 1 time per week. • None found regarding: Live Outcome/Action Step: "…will add up what she wants to see if she can afford it" for 1/2018. Action step is to be completed 1 time per week.		

DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.	• None found regarding: Live Outcome/Action Step: "…will identify where she wants to go and eat and how much money she has" for 1/2018. Action step is to be completed 1 time per week. • None found regarding: Live Outcome/Action Step: "…will order what she can afford" for 1/2018. Action step is to be completed 1 time per week. Individual #11 • None found regarding: Live Outcome/Action Step: "…will be prompted to use the bathroom" for 12/2017 – 2/2018. Action step is to be completed 1 time per day. • None found regarding: Live Outcome/Action Step: "…will be coached through her toileting routine" for 12/2017 – 2/2018. Action step is to be completed 1 time per day. • None found regarding: Fun Outcome/Action Step: "…will participate in community outing with … & … together including Special Olympics" for 12/2017 – 2/2018. Action step is to be completed 1 time per month.		

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and	Based on administrative 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 4 of 18 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #4 • According to the Fun Outcome; Action Step for "…will choose a recipe to bake" is to be completed 3 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018. • According to the Fun Outcome; Action Step for "…will bake meal of her choice and share with family" is to be completed 3 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018. Individual #5 • According to the Live Outcome; Action Step for "…will choose, prepare, pack and take his breakfast for his day" is to be completed 4 times per week. Evidence found indicated it was not being completed at the required	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 6: Individual Service Plan (ISP)** **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records** **20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.	frequency as indicated in the ISP for 12/2017 – 2/2018. Individual #16 • According to the Live Outcome; Action Step for "…will pick out an outfit his clothes the night before" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 – 2/2018. • According to the Fun Outcome; Action Step for "…will arrange an activity with a person of his choice" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2017 – 2/2018. • According to the Live Outcome; Action Step for "…will practice social interaction during the activity' is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2017 – 2/2018. **Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #8 • According to the Live Outcome; Action Step for "…will practice telling time on analog clock" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2017 and 2/2018.		

DD Waiver Provider Agencies are required to adhere to the following: 8. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 9. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 11. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 12. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 13. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 14. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.	• According to the Live Outcome; Action Step for "…will go over food options and identify how much things cost" 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 12/2017 and 2/2018. • According to the Live Outcome; Action Step for "…will add up what she wants to see if she can afford it" 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 12/2017 and 2/2018. • According to the Live Outcome; Action Step for "…will identify where she wants to go and eat and how much money she has" 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 12/2017 and 2/2018. • According to the Live Outcome; Action Step for "…will order what she can afford" 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 12/2017 and 2/2018.		

Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities.	Based on residential 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 4 of 15 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #3 • According to the Live Outcome; Action Step for "…will lose weight and weigh at least 120 pounds" is to be completed 1 time per day. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/1 – 8, 2018. *(Home visit 4/9/2018)* • According to the Live Outcome; Action Step for "…will diet and will participate in exercise activities" is to be completed 1 time per day. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/1 – 8, 2018. *(Home visit 4/9/2018)* • According to the Fun Outcome; Action Step for "…will decide on outings or activities with his family" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/1 – 6, 2018. *(Home visit 4/9/2018)*	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 6: Individual Service Plan (ISP)** **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records** **20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.	• According to the Health Outcome; Action Step for "…will follow his daily calorie intake" is to be completed 1 time per day. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/1 – 8, 2018. *(Home visit 4/9/2018)* • According to the Health Outcome; Action Step for "…will utilize his C-Pap device at night" is to be completed 1 time per day. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/1 – 8, 2018. *(Home visit 4/9/2018)* Individual #5 • According to the Live Outcome; Action Step for "…will choose, prepare, pack, and take his breakfast for his day" is to be completed 4 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/1 – 6, 2018. *(Home visit 4/11/2018)* • According to the Live Outcome; Action Step for "…will choose, prepare, pack, and take his lunch for his day" is to be completed 4 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/1 – 6, 2018. *(Home visit 4/11/2018)* Individual #9 • None found regarding: Live Outcome/Action Step: "…will practice writing cursive letters in the alphabet" for 4/1 – 6, 2018. Action step is to be completed 1 time per week.		

DD Waiver Provider Agencies are required to adhere to the following: 15. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 16. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 17. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 18. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 19. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 20. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 21. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.	Document maintained by the provider was blank. *(Home visit 4/11/2018)* • None found regarding: Fun Outcome/Action Step: "…will research activities" for 4/1 – 6, 2018. Action step is to be completed 1 time per week. Document maintained by the provider was blank. *(Home visit 4/11/2018)* Individual #16 • None found regarding: Fun Outcome/Action Step: "…will arrange an activity with a person of his choice" for 4/1 – 6, 2018. Action step is to be completed 1 time per week. Document maintained by the provider was blank. *(Home visit 4/10/2018)* • None found regarding: Fun Outcome/Action Step: "…will practice social interaction during the activity" for 4/1 – 6, 2018. Action step is to be completed 1 time per week. Document maintained by the provider was blank. *(Home visit 4/10/2018)*		

Tag # 1A38.1 Living Care Arrangement / Community Inclusion Reporting Requirements (Reporting Components)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 20: Provider Documentation and Client Records** **20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for	Based on record review, the Agency did not complete written status reports in compliance with standards for 1 of 18 individuals receiving Living Care Arrangements and / or Community Inclusion Services. Review of semi-annual reports found the following components were not addressed, as required: Individual #3 - The following components were not found in the Family Living Semi-Annual Report for 3/2017 – 6/2017; 7/2017- 12/2017: • No description of progress toward desired outcomes in the ISP.	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **Chapter 19: Provider Reporting Requirements** **19.5 Semi-Annual Reporting:** The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDSD for QA activities. Semi-annual reports are required as follows: 5. Semi-annual reports must contain at a minimum written documentation of: a. the name of the person and date on each page; b. the timeframe that the report covers; c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering; d. a description of progress towards Desired Outcomes in the ISP related to the service provided; e. a description of progress toward any			

service specific or treatment goals when applicable (e.g. health related goals for nursing); f. significant changes in routine or staffing if applicable; g. unusual or significant life events, including significant change of health or behavioral health condition; h. the signature of the agency staff responsible for preparing the report; and i. any other required elements by service type that are detailed in these standards. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) 3. Agency Requirements: E. Living Supports- Family Living Service Provider Agency Reporting Requirements:** 1. **Semi-Annual Reports:** Family Living Provider must submit written semi-annual status reports to the individual's Case Manager and other IDT Members no later than one hundred ninety (190) calendar days after the ISP effective date. When reports are developed in any other language than English, it is the responsibility of the provider to translate the reports into English. The semi-annual reports must contain the following written documentation: a. Name of individual and date on each page; b. Timely completion of relevant activities from ISP Action Plans; c. Progress towards desired outcomes in the ISP accomplished during the past six months; d. Significant changes in routine or staffing;			

e. Unusual or significant life events, including significant change of health condition; f. Data reports as determined by IDT members; and g. Signature of the agency staff responsible for preparing the reports.			

Tag # LS14 Residential Case File (ISP and Healthcare Requirements) *(Upheld by IRF)*	Condition of Participation Level Deficiency *(Upheld as result of Pilot 1)*		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 13 of 15 Individuals receiving Family Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Teaching and Support Strategies:** *Individual #17 - TSS not found for the following: Fun Outcome Statement / Action Steps:* • "…will participate in the activity" **Healthcare Passport:** • Not Current (#13) • Incomplete (#1, 2, 3, 4, 5, 6, 7, 9, 16, 18) *Note: Healthcare Passports for Individuals #1, 2, 3, 4, 5, 6, 7, 9, 16 and 18 upheld by IRF 7/27/2018.* **Health Care Plans:** • Constipation (#14) *Note: Healthcare Plan for Individual #14 upheld by IRF 7/27/2018.* **Medical Emergency Response Plans:** • Aspiration (#14) • Tube Feeding (#14) *Note: Medical Emergency Response Plans for Individual #14 upheld by IRF 7/27/2018.*	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. Requirements for the *Health Passport* and *Physician Consultation* form are: 2. The Primary and Secondary Provider Agencies must ensure that a current copy of the *Health Passport* and *Physician Consultation* forms are printed and available at all service delivery sites. Both forms must be reprinted and placed at all service delivery sites each time the e-CHAT is updated for any reason and whenever there is a change to			

contact information contained in the IDF. **Chapter 13: Nursing Services:** **13.2.9 Healthcare Plans (HCP)*:*** 1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. 2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary **13.2.10 *Medical Emergency Response Plan (MERP):*** 1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP. 2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.			

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A20 Direct Support Personnel Training *(Upheld by IRF)*	**Standard Level Deficiency** *(Modified as result of Pilot 1)*		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 17: Training Requirements:** The purpose of this chapter is to outline requirements for completing, reporting and documenting DDSD training requirements for DD Waiver Provider Agencies as well as requirements for certified trainers or mentors of DDSD Core curriculum training. **17.1 Training Requirements for Direct Support Personnel and Direct Support Supervisors:** Direct Support Personnel (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports. 1. DSP/DSS must successfully: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in 17.10 Individual-Specific Training below. b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14 c. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements d. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA	Based on record review, the Agency did not ensure Orientation and Training requirements were met for 1 of 148 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: **First Aid:** • Expired (#593) **CPR:** • Expired (#593) *Note: First Aid and CPR for #593 upheld by IRF 7/27/2018.*	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

requirements/guidelines. e. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). f. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using EPR. Agency DSP and DSS shall maintain certification in a DDSD-approved system if any person they support has a BCIP that includes the use of EPR. g. Complete and maintain certification in a DDSD-approved medication course if required to assist with medication delivery. h. Complete training regarding the HIPAA. 2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings and be on shift with a DSP who has completed the relevant IST. **17.1.2 Training Requirements for Service Coordinators (SC):** Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports. 1. A SC must successfully: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported, and as outlined in the 17.10 Individual-Specific Training below. b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14. c. Complete training in universal			

precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. d. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. e. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). f. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using emergency physical restraint. Agency SC shall maintain certification in a DDSD-approved system if a person they support has a Behavioral Crisis Intervention Plan that includes the use of emergency physical restraint. g. Complete and maintain certification in AWMD if required to assist with medications. h. Complete training regarding the HIPAA. 2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings.			

Tag # 1A22 Agency Personnel Competency *(Modified by IRF)*	Standard Level Deficiency *(Modified as result of Pilot 1)*		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 13: Nursing Services** ***13.2.11 Training and Implementation of Plans:*** 1. RNs and LPNs are required to provide Individual Specific Training (IST) regarding HCPs and MERPs. 2. The agency nurse is required to deliver and document training for DSP/DSS regarding the healthcare interventions/strategies and MERPs that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee as described in Chapter 17.10 Individual-Specific Training. **Chapter 17: Training Requirement** **17.10 Individual-Specific Training:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence.	Based on interview, the Agency did not ensure training competencies were met for 1 of 17 Direct Support Personnel. **When DSP were asked if they received training on the Individual's Individual Service Plan and what outcomes they are responsible for, the following was reported:** • DSP #626 stated, "Dress himself without prompts." According to the ISP Fun Outcome/Action Steps, the FLP is also responsible for "… will arrange an activity with a person of his choice" and "… will practice social interaction during the activity." Action steps are to be implemented 3 times per week. (Individual #16) **When DSP were asked, what are the steps did they need to take before assisting an individual with PRN medication, the following was reported:** • DSP #606 stated, "I would ask her and call her mom. I just assist by verbally telling her." When asked if he would call the nurse, DSP #606 stated, "No." Per DDSD standards 13.2.12 Medication Delivery DSP not related to the Individual must contact nurse prior to assisting with medication. (Individual #11) *Note: Finding for DSP #606 removed by IRF 7/27/2018.*	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported. 1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends. 2. IST for therapy-related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher. 3. The competency level of the training is based on the IST section of the ISP. 4. The person should be present for and involved in IST whenever possible. 5. Provider Agencies are responsible for tracking of IST requirements.			

6. Provider Agencies must arrange and ensure that DSP's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings. 7. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan.			

Tag # 1A43.1 General Events Reporting: Individual Reporting	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 19: Provider Reporting Requirements:** **19.2 General Events Reporting (GER):** The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows: 1. DD Waiver Provider Agencies approved to provide Customized In- Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use GER in the Therap system. 2. DD Waiver Provider Agencies referenced above are responsible for entering specified information into the GER section of the secure website operated under contract by Therap according to the GER Reporting Requirements in Appendix B GER Requirements. 3. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap. 4. GER does not replace a Provider Agency's obligations to report ANE or other reportable incidents as described in Chapter 18:	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 4 of 18 individuals. **The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and approved within 2 business days:** Individual #3 • General Events Report (GER) indicates on 7/8/2017 the Individual had an injury. (Injury). GER was approved 7/20/2017. • General Events Report (GER) indicates on 9/14/2017 the Individual had an injury. (Injury). GER was approved 9/26/2017. • General Events Report (GER) indicates on 9/25/2017 the Individual had an injury. (Injury). GER was approved 10/9/2017. • General Events Report (GER) indicates on 3/5/2018 the Individual had an infection. (Injury). GER was pending approval. Individual #4 • General Events Report (GER) indicates on 8/8/2017 the Individual had an injury. (Injury). GER was approved 9/20/2017. Individual #14 • General Events Report (GER) indicates on 4/23/2017 the Individual went to Urgent Care. (Urgent Care). GER was approved 5/8/2017.	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Incident Management System. 5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities. **Appendix B GER Requirements:** DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting: 1. *Effective immediately*, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau. 2. No alternative methods for reporting are permitted. **The following events need to be reported in the Therap GER:** • Emergency Room/Urgent Care/Emergency Medical Services • Falls Without Injury • Injury (including Falls, Choking, Skin Breakdown and Infection) • Law Enforcement Use • Medication Errors • Medication Documentation Errors • Missing Person/Elopement • Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission • PRN Psychotropic Medication • Restraint Related to Behavior • Suicide Attempt or Threat **Entry Guidance:** Provider Agencies must complete the following sections of the GER with detailed information: profile information,	• General Events Report (GER) indicates on 6/1/2017 the Individual went to Urgent Care. (Urgent Care). GER was approved 6/23/2017 Individual #15 • General Events Report (GER) indicates on 7/20/2017 the Individual was taken to the Emergency Room. (Emergency Room). GER was pending approval. • General Events Report (GER) indicates on 7/28/2017 the Individual had an injury. (Injury). GER was approved 8/22/2017. • General Events Report (GER) indicates on 1/31/2018 the Individual had surgery. Individual was discharged 2/2/2018. (Out of Home Placement - Hospital). GER was approved 2/22/2018.		

event information, other event information, general information, notification, actions taken or planned, and the review follow up comments section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Due Date
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 Administrative Case File: Healthcare Requirements & Follow-up ***(Upheld by IRF)***	**Condition of Participation Level Deficiency** *(Upheld as result of Pilot 1)*		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 3 Safeguards: 3.1.1 *Decision Consultation Process (DCP):*** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: 1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 7 of 18 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Inclusion Services (Individuals Receiving Inclusion Services Only):*** **Annual Physical** (#11) ***Living Care Arrangements / Community Inclusion Services (Individuals Receiving Multiple Services):*** **Annual Physical** (#5) *Note: Finding for Individual #5 upheld by IRF 7/27/2018.* **Dental Exam:** • Individual #2 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting. **Chapter 20: Provider Documentation and Client Records:** **20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create	• Individual #17 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. **Auditory Exam:** • Individual #17 - As indicated by collateral documentation reviewed, exam was completed on 8/2/2017. Exam stated, "Schedule an ear lavage of left canal. Immediately after lavage call our office to reschedule today's visit". No evidence of follow-up found. **Blood Levels:** • Individual #3 - As indicated by collateral documentation reviewed, lab work was ordered on 11/10/2017. No evidence of lab results were found for BMP, Lipid, and CBC. • Individual #7 - As indicated by collateral documentation reviewed, lab work was ordered on 5/8/2017. No evidence of lab results were found for TSH. **Blood Glucose:** • Individual #5 - As indicated by collateral documentation reviewed, lab work was completed on 9/3/2017. Per documentation "Glucose levels were high and should be confirmed with a follow-up test." No evidence of follow-up found. *Note: Finding for Individual #5 upheld by IRF 7/27/2018.* **Dermatology Exam:** • Individual #4 - As indicated by collateral documentation reviewed, exam was completed on 7/24/2017. Follow-up was to be completed in 3 months. No evidence of follow-up found.		

and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with	*Note: Finding for Individual #4 upheld by IRF 7/27/2018.*		

DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 *Health Passport and Physician Consultation Form:*** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. **Chapter 10: Living Care Arrangements (LCA) Living Supports-Supported Living: 10.3.9.6.1 Monitoring and Supervision** 4. Ensure and document the following: a. The person has a Primary Care Practitioner. b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist. c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist. d. The person receives a hearing test as recommended by a licensed audiologist.			

e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist. 5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine). **10.3.10.1 Living Care Arrangements (LCA) Living Supports-IMLS:** **10.3.10.2 General Requirements:** 9 . Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and annual dental checkup by a licensed dentist). **Chapter 13 Nursing Services: 13.2.3 General Requirements:** 1. Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **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. **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. **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. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications:** A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.			

Tag # 1A05 General Requirements / Agency Policy and Procedure Requirements	Condition of Participation Level Deficiency *(Upheld as result of Pilot 1)*		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 16: Qualified Provider Agencies** Qualified DD Waiver Provider Agencies must deliver DD Waiver services. DD Waiver Provider Agencies must have a current Provider Agreement and continually meet required screening, licensure, accreditation, and training requirements as well as continually adhere to the DD Waiver Service Standards. All Provider Agencies must comply with contract management activities to include any type of quality assurance review and/or compliance review completed by DDSD, the Division of Health Improvement (DHI) or other state agencies. **NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION: Provider Application** • Emergency and on-call procedures; • On-call nursing services that specifically state the nurse must be available to DSP during periods when a nurse is not present. The on-call nurse must be available to make an on-site visit when information provided by the DSP over the phone indicate, in the nurse's professional judgment, a need for a face to face assessment to determine appropriate action; • Incident Management Procedures that comply with the current NM Department of Health Improvement Incident Management Guide • Medication Assessment and Delivery Policy and Procedure; • Policy and procedures regarding delegation of specific nursing functions • Policies and procedures regarding the safe	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure Agency Personnel were aware of the Agency's On-Call Policy and Procedures for 2 of 17 Agency Personnel. **When DSP were asked if the agency had an on-call procedure, the following was reported:** • DSP #502 stated, "I just have the Service Coordinator number. I don't have the number to on call, just the office." (Individual #2) • DSP #503 stated, "I don't have an on-call number, just the office." (Individual #18) **When DSP were asked how long it took agency to respond when they were called, the following was reported:** • DSP #502 stated, "12 to 24 hours." (Individual #2)	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

transportation of individuals in the community and how you will comply with the New Mexico regulations governing the operation of motor vehicles **STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 39. POLICIES AND REGULATIONS** Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD. Additionally, the PROVIDER agrees to abide by all the following, whenever relevant to the delivery of services specified under this Provider Agreement: a. DD Waiver Service Standards and MF Waiver Service Standards. b. DEPARTMENT/DDSD Accreditation Mandate Policies. c. Policies and Procedures for Centralized Admission and Discharge Process for New Mexicans with Disabilities. d. Policies for Behavior Support Service Provisions. e. Rights of Individuals with Developmental Disabilities living in the Community, 7.26.3 NMAC. f. Service Plans for Individuals with Developmental Disability Community Programs, 7.26.5 NMAC. g. Requirement for Developmental Disability Community Programs, 7.26.6 NMAC. h. DEPARTMENT Client Complaint Procedures, 7.26.4 NMAC. i. Individual Transition Planning Process, 7.26.7 NMAC. j. Dispute Resolution Process, 7.26.8 NMAC.			

k. DEPARTMENT/DDSD Training Policies and Procedures. l. Fair Labor Standards Act. m. New Mexico Nursing Practice Act and New Mexico Board of Nursing requirements governing certified medication aides and administration of medications, 16.12.5 NMAC. n. Incident Reporting and Investigation Requirements for Providers of Community Based Services, 7.14.3 NMAC, and DHI/DEPARTMENT Incident Management System Policies and Procedures. o. DHI/DEPARTMENT Statewide Mortality Review Policy and Procedures. p. Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. q. Quality Management System and Review Requirements for Providers of Community Based Services, 7.1.13 NMAC. r. All Medicaid Regulations of the Medical Assistance Division of the HS D. s. Health Insurance Portability and Accountability Act (HIPAA). t. DEPARTMENT Sanctions Policy. u. All other regulations, standards, policies and procedures, guidelines and interpretive memoranda of the DDSD and the DHI of the DEPARTMENT. **Chapter 18 Incident Management:** **18.1 Training on Abuse, Neglect, and Exploitation (ANE) Recognition and Reporting:** All employees, contractors, and volunteers shall be trained on the in-person ANE training curriculum approved by DOH. Employees or volunteers can work with a DD Waiver participant prior to receiving the training only if directly supervised, at all times, by a trained staff. Provider Agencies are responsible for ensuring the training requirements outlined below are met.			

1. DDSD ANE On-line Refresher trainings shall be renewed annually, within one year of successful completion of the DDSD ANE classroom training. 2. Training shall be conducted in a language that is understood by the employee, subcontractor, or volunteer. 3. Training must be conducted by a DOH certified trainer and in accordance with the Train the Trainer curriculum provided by the DOH. 4. Documentation of an employee, subcontractor or volunteer's training must be maintained for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The			

training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer. **D. Training documentation:** All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule. **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **F. Quality assurance/quality improvement program for community-based service providers:** The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include			

written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program: **(1)** community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(3)** community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.			

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans) (Modified by IRF)	Standard Level Deficiency *(Modified as result of Pilot 1)*		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.	Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 2 of 18 individuals. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Special Health Care Needs:** ***Nutritional Evaluation:*** • Individual #5 - As indicated by collateral documentation reviewed, evaluation was completed on 8/31/2017. Follow-up was to be completed in 6 months. No evidence of follow-up found. *Note: Nutritional Evaluation for Individual #5 upheld by IRF 7/27/2018.* ***Nutritional Plan:*** • Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. Plan was not current. *Note: Nutritional Plan for Individual #3 upheld by IRF 7/27/2018.* **Health Care Plans:** ***Health Issues Prevented Desired Level of Participation**:* • Individual #5 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **Chapter 3 Safeguards: 3.1.1 *Decision Consultation Process (DCP):*** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: 2. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;	*Note: Healthcare Plan for Individual #5 removed by IRF 7/27/2018.*		

b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health			

decision in every setting. **Chapter 13 Nursing Services:** ***13.2.5 Electronic Nursing Assessment and Planning Process:*** The nursing assessment process includes several DDSD mandated tools: the electronic Comprehensive Nursing Assessment Tool (e-CHAT), the Aspiration Risk Screening Tool (ARST) and the Medication Administration Assessment Tool (MAAT) . This process includes developing and training Health Care Plans and Medical Emergency Response Plans. The following hierarchy is based on budgeted services and is used to identify which Provider Agency nurse has primary responsibility for completion of the nursing assessment process and related subsequent planning and training. Additional communication and collaboration for planning specific to CCS or CIE services may be needed. The hierarchy for Nursing Assessment and Planning responsibilities is: 1. Living Supports: Supported Living, IMLS or Family Living via ANS; 2. Customized Community Supports- Group; and 3. Adult Nursing Services (ANS): a. for persons in Community Inclusion with health-related needs; or b. if no residential services are budgeted but assessment is desired and health needs may exist. ***13.2.6 The Electronic Comprehensive Health Assessment Tool (e-CHAT)*** 1. The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person. 2. The nurse must see the person face-to-face to complete the nursing assessment. Additional			

information may be gathered from members of the IDT and other sources. 3. An e-CHAT is required for persons in FL, SL, IMLS, or CCS-Group. All other DD Waiver recipients may obtain an e-CHAT if needed or desired by adding ANS hours for assessment and consultation to their budget. 4. When completing the e-CHAT, the nurse is required to review and update the electronic record and consider the diagnoses, medications, treatments, and overall status of the person. Discussion with others may be needed to obtain critical information. 5. The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections. ***13.2.7 Aspiration Risk Management Screening Tool (ARST)*** ***13.2.8 Medication Administration Assessment Tool (MAAT):*** 1. A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting. 2. After completion of the MAAT, the nurse will present recommendations regarding the level of assistance with medication delivery (AWMD) to the IDT. A copy of the MAAT will be sent to all the team members two weeks before the annual ISP meeting and the original MAAT will be retained in the Provider Agency records. 3. Decisions about medication delivery are made by the IDT to promote a person's maximum independence and community integration. The IDT will reach consensus regarding which criteria the person meets, as indicated by the results of the MAAT and the			

nursing recommendations, and the decision is documented this in the ISP. **13.2.9 Healthcare Plans (HCP)*:*** 1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. 2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs plans that the nurse determines are warranted. ***13.2.10 Medical Emergency Response Plan (MERP):*** 1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP.			

2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation. **Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **Chapter 6 (CCS) 2. Service Requirements. E.** The agency nurse(s) for Customized Community Supports providers must provide the following services: 1. Implementation of pertinent PCP orders; ongoing oversight and monitoring of the individual's health status and medically related supports when receiving this service; **3. Agency Requirements: 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. **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. **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. **I. Health Care Requirements for Family Living: 5.** A nurse employed or contracted by the Family Living Supports provider must complete the e-CHAT, the Aspiration Risk Screening Tool, (ARST), and the Medication Administration Assessment Tool (MAAT) and any other assessments deemed appropriate on at least an annual basis for each individual served, upon significant change of clinical condition and upon return from any hospitalizations. In addition, the MAAT must be updated for any significant change of medication regime, change of route that requires delivery by licensed or certified staff, or when an individual has completed training designed to improve their skills to support self-administration. a. For newly-allocated or admitted individuals, assessments are required to be completed within three (3) business days of admission or two (2) weeks following the initial ISP meeting, whichever comes first. b. For individuals already in services, the required assessments are to be completed no more than forty-five (45) calendar days and at			

least fourteen (14) calendar days prior to the annual ISP meeting. c. Assessments must be updated within three (3) business days following any significant change of clinical condition and within three (3) business days following return from hospitalization. **d.** Other nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **e.** Develop any urgently needed interim Healthcare Plans or MERPs per DDSD policy pending authorization of ongoing Adult Nursing services as indicated by health status and individual/guardian choice.			

Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider *(Upheld by IRF)*	**Standard Level Deficiency** *(Modified as result of Pilot 1)*		
NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS: **A. Duty to report:** **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** **(1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline,	Based on record review, the Agency did not report suspected abuse, neglect, or exploitation**,** unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 18 Individuals. During the on-site survey, surveyors observed the following: During the on-site visit on 4/9/2018 at 5:30PM. Surveyors observed an approximately 5 inch hole in his bedroom ceiling from a leak in the roof. DSP #502 said she has been trying to find someone to fix it but it is expensive and her insurance won't cover it because it's not hail damage. She reported she did not have any idea of who else to go to, to get assistance. She also reported she had not notified anyone such as the case manager or agency. The agency was notified of this concern on 4/10/2017. As a result of what was observed the following incident(s) was reported: Individual #2 • A State Incident Report of Environmental Hazard was filed on 4/10/2018. Incident report was reported to APS **and/or** DHI.	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. **(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form. **(3) Limited provider investigation:** No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation. **(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse,			

neglect, or exploitation, the community-based service provider shall: **(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable; **(b)** be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and **(c)** provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057. **(5) Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident. **(6) Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative. **(7) Case manager or consultant notification by community-based service providers:** The responsible community-based service provider			

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

Tag # 1A31 Client Rights/Human Rights *(Modified by IRF)*	Condition of Participation Level Deficiency *(Upheld as result of Pilot 1)*		
NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. No current Human Rights Approval was found for the following: Based on record review, the Agency did not ensure the rights of Individuals were not restricted or limited for 2 of 18 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. No documentation was found regarding Human Rights Approval for the following: • Physical Restraint. No evidence found of Human Rights Committee approval. (Individual #11) • Gate Locked to Prevent Elopement. No evidence found of Human Rights Committee approval. (Individual #5) *(Individual #6)* *Noted: Finding modified by IRF 7/27/2018 to reflect correct Individual. Individual #5 removed and modified to Individual #6.*	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 2: Human Rights:** Civil rights apply to everyone, including all waiver participants, family members, guardians, natural supports, and Provider Agencies. Everyone has a responsibility to make sure those rights are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to best support the person. **Chapter 3 Safeguards: *3.3.1 HRC Procedural Requirements:*** 1. An invitation to participate in the HRC meeting of a rights restriction review will be given to the person (regardless of verbal or cognitive ability), his/her guardian, and/or a family member (if desired by the person), and the Behavior Support Consultant (BSC) at least 10 working days prior to the meeting (except for in emergency situations). If the person (and/or the guardian) does not wish to attend, his/her stated preferences may be brought to the meeting by someone whom the person chooses as his/her representative. 2. The Provider Agencies that are seeking to temporarily limit the person's right(s) (e.g., Living Supports, Community Inclusion, or BSC) are required to support the person's informed consent regarding the rights restriction, as well as their timely participation in the review. 3. The plan's author, designated staff (e.g., agency service coordinator) and/or the CM makes a written or oral presentation to the HRC. 4. The results of the HRC review are reported in writing to the person supported, the guardian, the BSC, the mental health or other specialized therapy provider, and the CM within three working days of the meeting.			

5. HRC committees are required to meet at least on a quarterly basis. 6. A quorum to conduct an HRC meeting is at least three voting members eligible to vote in each situation and at least one must be a community member at large. 7. HRC members who are directly involved in the services provided to the person must excuse themselves from voting in that situation. Each HRC is required to have a provision for emergency approval of rights restrictions based upon credible threats of harm against self or others that may arise between scheduled HRC meetings (e.g., locking up sharp knives after a serious attempt to injure self or others or a disclosure, with a credible plan, to seriously injure or kill someone). The confidential and HIPAA compliant emergency meeting may be via telephone, video or conference call, or secure email. Procedures may include an initial emergency phone meeting, and a subsequent follow-up emergency meeting in complex and/or ongoing situations. 8. The HRC with primary responsibility for implementation of the rights restriction will record all meeting minutes on an individual basis, i.e., each meeting discussion for an individual will be recorded separately, and minutes of all meetings will be retained at the agency for at least six years from the final date of continuance of the restriction. ***3.3.3 HRC and Behavioral Support:*** The HRC reviews temporary restrictions of rights that are related to medical issues or health and safety considerations such as decreased mobility (e.g., the use of bed rails due to risk of falling during the night while getting out of bed). However, other temporary restrictions may be implemented because of health and safety considerations arising from behavioral issues.			

Positive Behavioral Supports (PBS) are mandated and used when behavioral support is needed and desired by the person and/or the IDT. PBS emphasizes the acquisition and maintenance of positive skills (e.g. building healthy relationships) to increase the person's quality of life understanding that a natural reduction in other challenging behaviors will follow. At times, aversive interventions may be temporarily included as a part of a person's behavioral support (usually in the BCIP), and therefore, need to be reviewed prior to implementation as well as periodically while the restrictive intervention is in place. PBSPs not containing aversive interventions do not require HRC review or approval. Plans (e.g., ISPs, PBSPs, BCIPs PPMPs, and/or RMPs) that contain any aversive interventions are submitted to the HRC in advance of a meeting, except in emergency situations. **3.3.4 Interventions Requiring HRC Review and Approval:** HRCs must review prior to implementation, any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies, including but not limited to: 1. response cost; 2. restitution; 3. emergency physical restraint (EPR); 4. routine use of law enforcement as part of a BCIP; 5. routine use of emergency hospitalization procedures as part of a BCIP; 6. use of point systems; 7. use of intense, highly structured, and specialized treatment strategies, including level systems with response cost or failure to earn components; 8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical			

reasons; 9. use of PRN psychotropic medications; 10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand); 11. use of bed rails; 12. use of a device and/or monitoring system through PST may impact the person's privacy or other rights; or 13. use of any alarms to alert staff to a person's whereabouts. **3.4 Emergency Physical Restraint (EPR):** Every person shall be free from the use of restrictive physical crisis intervention measures that are unnecessary. Provider Agencies who support people who may occasionally need intervention such as Emergency Physical Restraint (EPR) are required to institute procedures to maximize safety. ***3.4.5 Human Rights Committee:*** The HRC reviews use of EPR. The BCIP may not be implemented without HRC review and approval whenever EPR or other restrictive measure(s) are included. Provider Agencies with an HRC are required to ensure that the HRCs: 1. participate in training regarding required constitution and oversight activities for HRCs; 2. review any BCIP, that include the use of EPR; 3. occur at least annually, occur in any quarter where EPR is used, and occur whenever any change to the BCIP is considered; 4. maintain HRC minutes approving or disallowing the use of EPR as written in a BCIP; and **5.** maintain HRC minutes of meetings reviewing the implementation of the BCIP when EPR is used.			

Tag # LS25 Residential Health & Safety (Supported Living & Family Living) *(Modified by IRF)*	Standard Level Deficiency *(Modified as result of Pilot 1)*		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 10: Living Care Arrangements (LCA)** **10.3.6 Requirements for Each Residence:** Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence: 1. has basic utilities, i.e., gas, power, water, and telephone; 2. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher; 3. has a general-purpose first aid kit; 4. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift; 5. has water temperature that does not exceed a safe temperature (110^0 F); 6. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP; 7. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy; 8. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 9. supports environmental modifications and assistive technology devices, 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;	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 2 of 15 Family Living residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Family Living Requirements:** • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#7) • 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 (#7, 10, 17) *Noted: Finding for Individual #10 removed by IRF 7/27/2018. Findings for Individual #7 & 17 upheld by IRF 7/27/2018.*	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

10. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed; 11. has the phone number for poison control within line of site of the telephone; 12. has general household appliances, and kitchen and dining utensils; 13. has proper food storage and cleaning supplies; 14. has adequate food for three meals a day and individual preferences; and 15. has at least two bathrooms for residences with more than two residents. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) Living Supports – Family Living Agency Requirements G. Residence Requirements for Living Supports- Family Living Services:** 1. Family Living Services providers must assure that each individual's residence is maintained to be clean, safe and comfortable and accommodates the individuals' daily living, social and leisure activities. In addition, the residence must: a. Maintain basic utilities, i.e., gas, power, water and telephone; b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; c. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system; d. Have a general-purpose first aid kit;			

e. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; f. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year; g. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and h. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag # LS27 Family Living Reimbursement *(Modified by IRF)*	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and h. the nature of services. 3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer. 4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any of	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Family Living Services for 2 of 15 individuals. Individual #4 December 2017 • The Agency billed 1 unit of Family Living (T2033 HB) on 12/23/2017. Documentation received accounted for .5 units. • The Agency billed 1 unit of Family Living (T2033 HB) on 12/24/2017. Documentation received accounted for .5 units. February 2018 • The Agency billed 1 unit of Family Living (T2033 HB) on 2/22/2018. Documentation received accounted for .5 units. • The Agency billed 1 unit of Family Living (T2033 HB) on 2/23/2018. Documentation received accounted for .5 units. • The Agency billed 1 unit of Family Living (T2033 HB) on 2/24/2018. Documentation received accounted for .5 units. Individual #9 January 2018 • The Agency billed 1 unit of Family Living (T2033 HB) on 1/31/2018. No documentation was found on 1/31/2018 to justify the 1 unit billed.	**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?)*: → **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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

the following for a period of at least six years from the payment date: a. treatment or care of any eligible recipient; b. services or goods provided to any eligible recipient; c. amounts paid by MAD on behalf of any eligible recipient; and d. any records required by MAD for the administration of Medicaid. **21.9 Billable Units:** The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: 1. A day is considered 24 hours from midnight to midnight. 2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period. 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. 4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows: a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%). b. The receiving Provider Agency bills the remaining days up to 340 for the ISP year.	*Note: Billing finding for Individual #9 removed by IRF 7/27/2018.* Individual #10 January 2018 • The Agency billed 1 unit of Family Living (T2033 HB) on 1/8/2018. No documentation was found on 1/8/2018 to justify the 1 unit billed. • The Agency billed 1 unit of Family Living (T2033 HB) on 1/18/2018. No documentation was found on 1/18/2018 to justify the 1 unit billed. February 2018 • The Agency billed 1 unit of Family Living (T2033 HB) on 2/23/2018. No documentation was found on 2/23/2018 to justify the 1 unit billed.		

21.9.2 Requirements for Monthly Units: For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days. 2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. 4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit. **21.9.3 Requirements for 15-minute and hourly units**: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following: 1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2. 2. Services that last in their entirety less than eight minutes cannot be billed. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) 5. REIMBURSEMENT** **A.** Family Living Services Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Family Living Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session			

of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations 1. From the payments received for Family Living services, the Family Living Agency must: a. Provide a minimum payment to the contracted primary caregiver of $2,051 per month; and b. Provide or arrange up to seven hundred fifty (750) hours of substitute care as sick leave or relief for the primary caregiver. Under no circumstances can the Family Living Provider agency limit how these hours will be used over the course of the ISP year. It is not allowed to limit the number of substitute care hours used in a given time period, other than an ISP year. **B. Billable Units:** 1. The billable unit for Family Living is based on a daily rate. A day is considered 24 hours from midnight to midnight. If 12 or less hours of service, are provided then one half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24 hour period. 2. The maximum allowable billable units cannot exceed three hundred forty (340) days per ISP year or one hundred seventy (170) days per six (6) months.			

Date: July 27, 2018

To: Angelique Tafoya, Executive Director
Provider: Alta Mira Specialized Family Services, Inc.
Address: 1605 Carlisle Blvd NE
State/Zip: Albuquerque, New Mexico 87110

E-mail Address: ATafoya@AltaMiraNM.org

CC: Brett Penfold, Board President
Board Chair
E-Mail Address sbjavaman41@aol.com

Region: Metro
Survey Date: April 6 – 13, 2018

Program Surveyed: Developmental Disabilities Waiver

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

Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Tafoya,

Your request for a Reconsideration of Findings was received on June 27, 2018. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A08.3

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the QMB Document Request Form, the Teaching and Support Strategies for the Work/Education/Volunteer Outcome for Individual #18 were requested from and signed by an agency representative on 4/11/2018. The agency was given the opportunity to reconcile documentation and a final copy of the QMB Document Request Form, still listing these items as not provided or justified, was provided to the agency and signed by Angelique Tafoya on

4/13/2018 indicating acknowledgement of the findings. No documentation and/or justification was provided to surveyors while on-site to refute the findings.

Regarding Tag # 1A08.1

Determination: The IRF committee is modifying the original tag in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the QMB Document Request Form, the progress note for Individual #9 on 1/31/2018 was not listed as missing. This finding will be removed. The second date disputed for Individual #9 on the IRF (1/23/2018) was not cited on the Report of Findings and therefore no action was taken on this finding. The remaining citations noted in this tag were not disputed.

Regarding Tag # LS14

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. The Healthcare Passports for Individuals #1, 2, 3, 4, 5, 6, 7, 9, 16 and 18 and the Healthcare Plan and Medical Emergency Response Plans for Individual #14 will be upheld. Findings listed in this tag are in reference to the Residential Case File not the Agency Case File. At the residence, a documentation request form is not given but documentation not found and/or incomplete in the home was reviewed with residential staff and the residential staff signed acknowledgement on the QMB Residential Case File Review Tool indicating they were informed of the items not found or incomplete and were also provided the opportunity and could not reconcile the items.

Regarding Tag #1A20

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Although the training certificate for Individual #593 has been updated to include the expiration date for the CPR and First Aid trainings, this information was not provided during the on-site survey nor was a valid CPR/First Aid card from the American Heart Association provided.

Regarding Tag # 1A22

Determination: The IRF committee is modifying the original tag in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Since DSP #606 does not administer medication to Individual #11, this citation will be removed. The remaining citation noted in this tag was not disputed.

Regarding Tag # 1A08.2

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Documentation provided during the IRF process showed that appointments and/or modification to the original appointment notes for Individual #4's dermatology exam and Individual #5's annual physical were held after the survey date, therefore citations at the time of the survey were valid. In addition, the medical note provided for Individual #5 in regard to blood glucose does indicate that follow up is needed due to an elevated glucose value. This information can be found on page 2 of the Results Letter. The citation disputed for Individual #10 was not cited on the report, therefore no action was taken on this finding. The remaining citations noted in this tag were not disputed.

Regarding Tag # 1A15.2

Determination: The IRF committee is modifying the original tag in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation provided during the IRF, the finding for the missing Healthcare Plan for Individual #5 will be removed. The Nutritional Evaluation for Individual #5 and the Nutritional Plan for Individual #3 will be upheld. A final copy of the QMB Document Request Form, still listing these items as not provided or justified, was provided to the agency and signed by Angelique Tafoya on 4/13/2018 indicating acknowledgement of the findings. No documentation and/or justification was provided to surveyors while on-site to refute the findings. In addition, the decision to discontinue routine nutritional services for Individual #5 and the nutritional report for Individual #3 provided during the IRF process were not completed until after the on-site survey date.

Regarding Tag #1A27.2

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Although this incident was screened out by IMB, during the QMB on-site survey an Incident Report was made therefore this finding is upheld.

Regarding Tag # 1A31

Determination: The IRF committee is modifying the original tag in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. In speaking with the QMB Team Lead and reviewing the QMB survey tools, Individual #5 was cited in error. This citation was intended for Individual #6. Please complete the Plan of Correction for Individual #6 and the report of findings will be modified to show this correction.

Regarding Tag # LS25

Determination: The IRF committee is modifying the original tag in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. The finding for written procedures for emergency placement and relocation for Individual #10 will be removed. The findings for written procedures for emergency placement and relocation for Individuals #7 and 17 were marked as missing and reviewed with residential staff during the residential home visit on 4/11/2018 for Individual #7 and 4/9/2018 for Individual #11. Residential staff signed acknowledgement on the QMB Residential Observation Tool indicating they were informed of the missing procedure and were provided the opportunity and could not locate it.

Regarding Tag #LS27

Determination: The IRF committee is modifying the original tag in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on QMB Document Request Form, the progress note for Individual #9 on 1/31/2018 was not listed as missing. This finding will be removed. The remaining citation noted in this tag was not disputed.

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

Thank you.
Respectfully,

Crystal Lopez-Beck

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

Q.18.4.DDW.D0067.5.RTN.12.18.208

Date: September 12, 2018

To: Angelique Tafoya, Executive Director
Provider: Alta Mira Specialized Family Services, Inc.
Address: 1605 Carlisle Blvd NE
State/Zip: Albuquerque, New Mexico 87110

E-mail Address: ATafoya@AltaMiraNM.org

CC: Brett Penfold, Board President
Board Chair
E-Mail Address sbjavaman41@aol.com

Region: Metro
Survey Date: April 6 – 13, 2018

Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: ***2012:*** Family Living, Customized Community Supports and Customized In-Home Supports

Survey Type: Routine

Dear Ms. Tafoya;

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. In addition, as a result of your compliance survey, completed during Pilot 1 (April 1 – June 30, 2018) of the revised QMB survey process, your agency has been rescored based on changes made after the pilot. You are now in Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags. Therefore, an on-site verification survey is no longer necessary.

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.18.4.DDW.D0067.5.RTN.09.18.255

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