



SUSANA MARTINEZ, GOVERNOR

LYNN GALLAGHER, CABINET SECRETARY

Date: October 12, 2018

To: Shelley Hennie, Executive Director
Provider: FootPrints Home Care, Inc.
Address: 5941 Jefferson Street NE Ste. A
State/Zip: Albuquerque, New Mexico 87109

E-mail Address: ShelleyH@fphcinc.com

Region: Metro
Survey Date: September 21 - 25, 2018

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012:** Customized In-Home Supports

Survey Type: Routine Survey

Team Leader: Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Kandis Gomez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Shelley Hennie;

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 with one to five (1 – 5) Condition of Participation Level Tags (*refer to Attachment D for details*). The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 1A05 General Provider Requirements/Agency Policy and Procedures Requirements
- Tag # 1A09.1 Medication Delivery PRN Medication Administration
- Tag # 1A09.2 Medication Delivery - Nurse Approval for PRN Medication
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)
- Tag # 1A20 Direct Support Personnel Training

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>



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The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File (Other Required Documents)
- Tag # 1A03 Continuous Quality Improvement System & KPIs
- Tag # 1A09.0 Medication Delivery Routine Medication Administration
- Tag # 1A09.1.0 Medication Delivery PRN Medication Administration

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

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,

Lora Norby,

Lora Norby,
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	September 21, 2018
Contact:	<u>FootPrints Home Care, Inc.</u> Shelley Hennie, Executive Director <u>DOH/DHI/QMB</u> Lora Norby, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	September 24, 2018
Present:	<u>FootPrints Home Care, Inc.</u> Shelley Hennie, Executive Director Stephanie Smith, Service Coordinator <u>DOH/DHI/QMB</u> Lora Norby, Team Lead/Healthcare Surveyor Kandis Gomez, AA, Healthcare Surveyor
Exit Conference Date:	September 25, 2018
Present:	<u>FootPrints Home Care, Inc.</u> Shelley Hennie, Executive Director Stephanie Smith, Service Coordinator <u>DOH/DHI/QMB</u> Lora Norby, Team Lead/Healthcare Surveyor Kandis Gomez, AA, Healthcare Surveyor <u>DDSD – Metro Regional Office</u> Marie Velasco, Social and Community Services Coordinator
Administrative Locations Visited	1
Total Sample Size	1 0 - <i>Jackson</i> Class Members 1 - <i>Non-Jackson</i> Class Member 1 - Customized In-Home Supports
Persons Served Records Reviewed	1
Persons Served Not Seen and/or Not Available	1
Direct Support Personnel Interviewed	1
Direct Support Personnel Records Reviewed	6
Service Coordinator Records Reviewed	1
Administrative Interviews	1

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Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- 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

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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 Living Care Arrangements and Community Inclusion are as follows:

Service Domain: Service Plan: ISP Implementation - *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)

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.*

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

- **1A20** - Direct Support Personnel Training

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- 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)

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.

QMB Determinations of Compliance

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or has no deficiencies at the Condition of Participation Level. 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 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.
2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

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. 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 17 or more Standard Level Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any tag.
2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Standard Level Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
COP Level Tags:	0 COP	0 COP	0 COP	0 COP	1 to 5 COP	0 to 5 CoPs	6 or more COP
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
<i>“Non-Compliance”</i>						17 or more Standard Level Tags with 75 to 100% of the Individuals in the sample cited in any tag.	Any Amount of Standard Level Tags and 6 or more Conditions of Participation Level Tags.
<i>“Partial Compliance with Standard Level tags <u>and</u> Condition of Participation Level Tags”</i>					Any Amount of Standard level Tags, plus 1 to 5 Conditions of Participation Level tags.		
<i>“Partial Compliance with Standard Level tags”</i>			up to 16 Standard Level Tags with 75 to 100% of the individuals in the sample cited in any tag.	17 or more Standard Level Tags with 50 to 74% of the individuals in the sample cited any tag.			
<i>“Compliance”</i>	Up to 16 Standard Level Tags with 0 to 74% of the individuals in the sample cited in any tag.	17 or more Standard Level Tags with 0 to 49% of the individuals in the sample cited in any tag.					

Agency: FootPrints Home Care, Inc. - Metro Region
Program: Developmental Disabilities Waiver
Service: 2012: Customized In-Home Supports
Survey Type: Routine
Survey Date: September 21 - 25, 2018

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<i>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.</i>			
Tag # 1A08 Administrative Case File (Other Required Documents)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p>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.</p> <p>DD Waiver Provider Agencies are required to adhere to the following:</p> <ol style="list-style-type: none"> 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 	<p>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 1 Individual.</p> <p>Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p>Occupational Therapy Plan (Therapy Intervention Plan TIP)</p> <ul style="list-style-type: none"> • Not Current (#1) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>20.5.1 Individual Data Form (IDF): The Individual Data Form provides an overview of demographic information as well as other key personal, programmatic, insurance, and health related information. It lists medical information; assistive technology or adaptive equipment; diagnoses; allergies; information about whether a guardian or advance directives are in place; information about behavioral and health related needs; contacts of Provider Agencies and team members and other critical information. The IDF automatically loads information into other fields and forms and must be complete and kept current. This form is initiated by the CM. It must be opened and continuously updated by Living Supports, CCS- Group, ANS, CIHS and case management when applicable to the person in order for accurate data to auto populate other documents like the Health Passport and Physician Consultation Form. Although the Primary Provider Agency is ultimately responsible for keeping this form current, each provider collaborates and communicates critical information to update this form.</p>			
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Chapter 3: Safeguards

3.1.2 Team Justification Process: DD Waiver participants may receive evaluations or reviews conducted by a variety of professionals or clinicians. These evaluations or reviews typically include recommendations or suggestions for the person/guardian or the team to consider. The team justification process includes:

1. Discussion and decisions about non-health related recommendations are documented on the Team Justification form.
2. The Team Justification form documents that the person/guardian or team has considered the recommendations and has decided:
 - a. to implement the recommendation;
 - b. to create an action plan and revise the ISP, if necessary; or
 - c. not to implement the recommendation currently.
3. All DD Waiver Provider Agencies participate in information gathering, IDT meeting attendance, and accessing supplemental resources if needed and desired.
4. The CM ensures that the Team Justification Process is followed and complete.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Qualified Providers - The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.			
Tag # 1A20 Direct Support Personnel Training	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p>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.</p> <p>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.</p> <p>1. DSP/DSS must successfully:</p> <p>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.</p> <p>b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14</p> <p>c. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements</p> <p>d. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines.</p> <p>e. Complete relevant training in accordance with OSHA requirements (if job involves exposure to</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 2 of 6 Direct Support Personnel.</p> <p>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <p>Assisting with Medication Delivery:</p> <ul style="list-style-type: none"> Expired (#500, 502) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): → </p>	<p> </p>

<p>hazardous chemicals).</p> <p>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.</p> <p>g. Complete and maintain certification in a DDSD-approved medication course if required to assist with medication delivery.</p> <p>h. Complete training regarding the HIPAA.</p> <p>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.</p> <p>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.</p> <p>1. A SC must successfully:</p> <p>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.</p> <p>b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14.</p> <p>c. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.</p> <p>d. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines.</p> <p>e. Complete relevant training in accordance with</p>			
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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.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Health and Welfare - The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.			
Tag # 1A03 Continuous Quality Improvement System & KPIs	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p>Chapter 22: Quality Improvement Strategy (QIS): A QIS at the provider level is directly linked to the organization's service delivery approach or underlying provision of services. To achieve a higher level of performance and improve quality, an organization is required to have an efficient and effective QIS. The QIS is required to follow four key principles:</p> <ol style="list-style-type: none"> 1. quality improvement work in systems and processes; 2. focus on participants; 3. focus on being part of the team; and 4. focus on use of the data. <p>As part of a QIS, Provider Agencies are required to evaluate their performance based on the four key principles outlined above. Provider Agencies are required to identify areas of improvement, issues that impact quality of services, and areas of non-compliance with the DD Waiver Service Standards or any other program requirements. The findings should help inform the agency's QI plan.</p> <p>22.2 QI Plan and Key Performance Indicators (KPI): Findings from a discovery process should result in a QI plan. The QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving goals, and identifying opportunities for improvement. The QI plan describes the processes that the Provider Agency uses in each phase of the QIS: discovery, remediation, and sustained improvement. It describes the frequency of data</p>	<p>Based on record review and interview, the Agency did not maintain or implement a Quality Improvement System (QIS), as required by standards.</p> <p>Review of information found:</p> <p>No evidence of a Quality Improvement Plan.</p> <p>When #508 was asked, if the Agency had a Quality Improvement Plan (QIP), the follow was reported:</p> <ul style="list-style-type: none"> • #508 stated, "Yes, but I don't have access to it right now, I'm trying to get that for you before you leave." <p>When #508 was asked if the Agency had a Quality Improvement Committee and to provide evidence of when meetings occurred, the following was reported:</p> <ul style="list-style-type: none"> • #508 stated, "The committee would be myself and members of the board, but I don't have access to committee meeting dates right now." <p>No evidence of a Quality Improvement Plan or Quality Improvement Committee meeting minutes were provided during the on-site survey on September 21 – 25, 2018 or prior to the exit on September 25th.</p>	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

collection, the source and types of data gathered, as well as the methods used to analyze data and measure performance. The QI plan must describe how the data collected will be used to improve the delivery of services and must describe the methods used to evaluate whether implementation of improvements is working. The QI plan shall address, at minimum, three key performance indicators (KPI). The KPI are determined by DOH-DDSQI) on an annual basis or as determined necessary.

22.3 Implementing a QI Committee:

A QI committee must convene on at least a quarterly basis and more frequently if needed. The QI Committee convenes to review data; to identify any deficiencies, trends, patterns, or concerns; to remedy deficiencies; and to identify opportunities for QI. QI Committee meetings must be documented and include a review of at least the following:

1. Activities or processes related to discovery, i.e., monitoring and recording the findings;
2. The entities or individuals responsible for conducting the discovery/monitoring process;
3. The types of information used to measure performance;
4. The frequency with which performance is measured; and
5. The activities implemented to improve performance.

22.4 Preparation of an Annual Report:

The Provider Agency must complete an annual report based on the quality assurance (QA) activities and the QI Plan that the agency has implemented during the year. The annual report shall:

1. Be submitted to the DDSD PEU by February 15th of each calendar year.
2. Be kept on file at the agency, and made available to DOH, including DHI upon request.
3. Address the Provider Agency's QA or

<p>compliance with at least the following:</p> <ul style="list-style-type: none"> a. compliance with DDSD Training Requirements; b. compliance with reporting requirements, including reporting of ANE; c. timely submission of documentation for budget development and approval; d. presence and completeness of required documentation; e. compliance with CCHS, EAR, and Licensing requirements as applicable; and f. a summary of all corrective plans implemented over the last 24 months, demonstrating closure with any deficiencies or findings as well as ongoing compliance and sustainability. Corrective plans include but are not limited to: <ul style="list-style-type: none"> i. IQR findings; ii. CPA Plans related to ANE reporting; iii. POCs related to QMB compliance surveys; and iv. PIPs related to Regional Office Contract Management. <p>4. Address the Provider Agency QI with at least the following:</p> <ul style="list-style-type: none"> a. data analysis related to the DDSD required KPI; and b. the five elements required to be discussed by the QI committee each quarter. 			
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Tag # 1A05 General Provider Requirements/Agency Policy and Procedures Requirements	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p>Chapter 16: Qualified Provider Agencies</p> <p>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.</p> <p>NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION: Provider Application</p> <p>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</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review and interview, the Agency did not develop, implement and / or comply with written policies and procedures to protect the physical/mental health of individuals that complies with all DDSD requirements.</p> <p>Review of Agency policies & procedures found no evidence of the following:</p> <ul style="list-style-type: none"> • Policies and procedures regarding the safe transportation of individuals. <p>When #508 was asked, if the Agency had policies and procedures regarding the safe transportation of individuals in the community and how the agency complies with the New Mexico regulations governing the operation of motor vehicles, the following was reported:</p> <ul style="list-style-type: none"> • #508 stated, "Currently personnel are trained on the Individual's van and they watch a video on defensive driving. We don't have a policy." 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

Policies and procedures regarding the safe 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.

<p>k. DEPARTMENT/DDSD Training Policies and Procedures.</p> <p>l. Fair Labor Standards Act.</p> <p>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.</p> <p>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.</p> <p>o. DHI/DEPARTMENT Statewide Mortality Review Policy and Procedures.</p> <p>p. Caregivers Criminal History Screening Requirements, 7.1.9 NMAC.</p> <p>q. Quality Management System and Review Requirements for Providers of Community Based Services, 7.1.13 NMAC.</p> <p>r. All Medicaid Regulations of the Medical Assistance Division of the HS D.</p> <p>s. Health Insurance Portability and Accountability Act (HIPAA).</p> <p>t. DEPARTMENT Sanctions Policy.</p> <p>u. All other regulations, standards, policies and procedures, guidelines and interpretive memoranda of the DDSD and the DHI of the DEPARTMENT.</p> <p>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.</p>			
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1. DDS ANE On-line Refresher trainings shall be renewed annually, within one year of successful completion of the DDS 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

<p>include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer.</p> <p>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.</p> <p>NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:</p> <p>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</p>			
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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 # 1A09.0 Medication Delivery Routine Medication Administration	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p>Chapter 20: Provider Documentation and Client Records</p> <p>20.6 Medication Administration Record (MAR): A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for:</p> <ol style="list-style-type: none"> 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. <p>8. Including the following on the MAR:</p> <ol style="list-style-type: none"> a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or 	<p>Medication Administration Records (MAR) were reviewed for the months of July and August 2018.</p> <p>Based on record review, 1 of 1 Individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</p> <p>Individual #1 August 2018</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Vitamin D3 2000 units (1 time daily) • Colace 100mg (3 times weekly Monday, Wednesday, Friday) • Colace 100mg (3 times weekly Tuesday, Thursday, Saturday) • Calcium Carb 1000mg (1 time daily) • Introvale (1 time daily) • Ascorbic Acid 500mg (1 time daily) <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Introvale (1 time daily) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Vitamin D3 2000 units (1 time daily) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	<p> </p>

<p>discontinued medications or treatments; d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment.</p> <p>Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery: Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training; 2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR)</p>	<ul style="list-style-type: none"> • Colace 100mg (3 times weekly Monday, Wednesday, Friday) • Calcium Carb 1000mg (1 time daily) • Introvale (1 time daily) • Colace 100mg (3 times weekly Tuesday, Thursday, Saturday) • Ascorbic Acid 500mg (1 time daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Vitamin D3 2000 units (1 time daily) • Colace 100mg (3 times weekly Monday, Wednesday, Friday) • Colace 100mg (3 times weekly Tuesday, Thursday, Saturday) • Ascorbic Acid 500mg(1 time daily) 		
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Tag # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p>Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR): A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for:</p> <ol style="list-style-type: none"> 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. <ol style="list-style-type: none"> 7. Including the following on the MAR: <ol style="list-style-type: none"> a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all 	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Medication Administration Records (MAR) were reviewed for the months of July and August 2018.</p> <p>Based on record review, 1 of 1 Individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:</p> <p>Individual #1 August 2018 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Ibuprofen 200mg - PRN - 8/9 (given 1 time) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (<i>What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

<p>ordered routine or PRN prescriptions or treatments; over the counter (OTC) or “comfort” medications or treatments and all self-selected herbal or vitamin therapy;</p> <ul style="list-style-type: none"> c. Documentation of all time limited or discontinued medications or treatments; d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: <ul style="list-style-type: none"> i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. <p>Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery:</p>			
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Living Supports Provider Agencies must support and comply with:

1. the processes identified in the DDSD AWMD training;
2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services;
3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and
4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).

Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR): A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for:</p> <ol style="list-style-type: none"> 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: <ol style="list-style-type: none"> a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; 	<p>Medication Administration Records (MAR) were reviewed for the months of July and August 2018.</p> <p>Based on record review, 1 of 1 Individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:</p> <p>Individual #1 August 2018 Medication Administration Records did not contain the exact amount to be used in a 24-hour period:</p> <ul style="list-style-type: none"> • Acetaminophen 325 mg (PRN) • Baclofen 10mg (PRN) • Certirizine HCL 10mg (PRN) • Clindamycin Phosphate 1% (PRN) • Diphenhydramine 25mg (PRN) • Fleet Enema 19-7gram/118ml (PRN) • Ibuprofen 200mg (PRN) • Nystatin Triamcinolone 100,000-0.1unit (PRN) • Pseudoephedrine 30mg (PRN) • Sumatriptan 25mg (PRN) • Triamcinolone 0.025% (PRN) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials;</p> <p>e. Documentation of refused, missed, or held medications or treatments;</p> <p>f. Documentation of any allergic reaction that occurred due to medication or treatments; and</p> <p>g. For PRN medications or treatments:</p> <p>i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period;</p> <p>ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and</p> <p>iii. documentation of the effectiveness of the PRN medication or treatment.</p> <p>Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery: Living Supports Provider Agencies must support and comply with:</p> <ol style="list-style-type: none"> 1. the processes identified in the DDSD AWMD training; 2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR). 	<p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Baclofen 10mg (PRN) • Cetirizine HCL 10mg (PRN) • Diphenhydramine 25mg (PRN) • Ibuprofen 200mg (PRN) • Pseudoephedrine 30mg (PRN) 		
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Tag # 1A09.2 Medication Delivery - Nurse Approval for PRN Medication	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p>Chapter 13 Nursing Services:</p> <p>13.2.12 Medication Delivery: Nurses are required to:</p> <ol style="list-style-type: none"> 1. Be aware of the New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations. 2. Communicate with the Primary Care Practitioner and relevant specialists regarding medications and any concerns with medications or side effects. 3. Educate the person, guardian, family, and IDT regarding the use and implications of medications as needed. 4. Administer medications when required, such as intravenous medications; other specific injections; via NG tube; non-premixed nebulizer treatments or new prescriptions that have an ordered assessment. 5. Monitor the MAR or treatment records at least monthly for accuracy, PRN use and errors. 6. Respond to calls requesting delivery of PRNs from AWMD trained DSP and non-related (surrogate or host) Family Living Provider Agencies. 7. Assure that orders for PRN medications or treatments have: <ol style="list-style-type: none"> a. clear instructions for use; b. observable signs/symptoms or circumstances in which the medication is to be used or withheld; and c. documentation of the response to and effectiveness of the PRN medication administered. 8. Monitor the person's response to the use of routine or PRN pain medication and contact the prescriber as needed regarding its effectiveness. 9. Assure clear documentation when PRN 	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not maintain documentation of PRN usage as required by standard for 1 of 1 Individuals.</p> <p>Individual #1 August 2018</p> <p>No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication:</p> <ul style="list-style-type: none"> • Ibuprofen 200mg - PRN - 8/9 (given 1 time) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	<p> </p>

<p>medications are used, to include:</p> <ul style="list-style-type: none">a. DSP contact with nurse prior to assisting with medication.i. The only exception to prior consultation with the agency nurse is to administer selected emergency medications as listed on the Publications section of the DOH-DDSD -Clinical Services Website https://nmhealth.org/about/ddsd/pgsv/clinical/.b. Nursing instructions for use of the medication.c. Nursing follow-up on the results of the PRN use.d. When the nurse administers the PRN medication, the reasons why the medications were given and the person's response to the medication.			
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Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p>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.</p> <p>DD Waiver Provider Agencies are required to adhere to the following:</p> <ol style="list-style-type: none"> 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 	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 1 of 1 Individuals.</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p>Electronic Comprehensive Health Assessment Tool (eCHAT):</p> <ul style="list-style-type: none"> • Not approved within 3-days of being completed (#1) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	<p> </p>

<p>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.</p> <p>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.</p> <p>7. All records pertaining to JCMs must be retained permanently and must be made available to DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p>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:</p> <p>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:</p> <ul style="list-style-type: none"> 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 			
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<p>members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy;</p> <p>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and</p> <p>d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>c. Providers support the person/guardian to make an informed decision.</p> <p>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.</p> <p>Chapter 13 Nursing Services: 13.2.5 Electronic Nursing Assessment and Planning Process: The nursing assessment process includes several DDSD mandated tools:</p>			
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<p>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.</p> <p>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.</p> <p>The hierarchy for Nursing Assessment and Planning responsibilities is:</p> <ol style="list-style-type: none"> 1. Living Supports: Supported Living, IMLS or Family Living via ANS; 2. Customized Community Supports- Group; and 3. Adult Nursing Services (ANS): <ol style="list-style-type: none"> 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. <p>13.2.6 The Electronic Comprehensive Health Assessment Tool (e-CHAT)</p> <ol style="list-style-type: none"> 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 			
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<p>and consultation to their budget.</p> <p>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.</p> <p>5. The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections.</p> <p>13.2.7 Aspiration Risk Management Screening Tool (ARST)</p> <p>13.2.8 Medication Administration Assessment Tool (MAAT):</p> <p>1. A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting.</p> <p>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.</p> <p>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.</p> <p>13.2.9 Healthcare Plans (HCP):</p> <p>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,</p>			
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<p>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.</p> <p>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.</p> <p>13.2.10 Medical Emergency Response Plan (MERP):</p> <p>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.</p> <p>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.</p> <p>Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and Physician Consultation Form: All Primary and</p>			
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<p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p>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.</p> <p>Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p>Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for</p>			
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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.

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 #1A12 All Services Reimbursement	No Deficient Practices Found		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p>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:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 	<p>Based on record review, the Agency maintained all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving for 1 of 1 Individuals.</p> <p><i>Progress notes and billing records supported billing activities for the months of June, July and August 2018 for the following services:</i></p>		

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.

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.

NMAC 8.302.1.17 Effective Date 9-15-08

Record Keeping and Documentation

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

Detail Required in Records - Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering,

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

Services Billed by Units of Time -

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

Records Retention - A provider who receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

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

Date: December 7, 2018

To: Shelley Hennie, Executive Director
Provider: FootPrints Home Care, Inc.
Address: 5941 Jefferson Street NE Ste. A
State/Zip: Albuquerque, New Mexico 87109

E-mail Address: ShelleyH@fphcinc.com

Region: Metro
Survey Date: September 21 - 25, 2018

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012: Customized In-Home Supports**

Survey Type: Routine Survey

Dear Shelley Hennie;

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.19.1.DDW.D0289.5.RTN.09.18.341