

Reviewed by IRF 12/18/2018

Date: October 17, 2018

To: Hector Johnson, Executive Director
 Provider: Community Options, Inc.
 Address: 2500 Missouri
 State/Zip: Las Cruces, New Mexico 88011

E-mail Address: Hector.Johnson@comop.org

Region: Southwest Region
 Survey Date: August 31 - September 6, 2018
 Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2007:** Supported Living, Adult Habilitation
2012: Supported Living, Family Living, Customized Community Supports, Community Integrated Employment Services
2018: Customized Community Supports, Community Integrated Employment Services

Survey Type: Routine Survey

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

Team Members: Debbie Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Michele Beck, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Wolf Krusemark, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Johnson;

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.

DIVISION OF HEALTH IMPROVEMENT

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



QMB Report of Findings – Community Options, Inc. – SW Region – August 31 – September 6, 2018

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

- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up

The following tags are identified as Standard Level Deficiencies:

- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation
- Tag # 1A32.2 Individual Service Plan Implementation
- Tag # 1A38 LS/IS Reporting Requirements
- Tag # 1A20 Direct Support Personnel Training
- Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry
- Tag # 1A43.1 General Events Reporting: Individual Reporting
- Tag # IS30 Customized Community Supports Reimbursement
- Tag # LS26 Supported Living Reimbursement

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

Plan of Correction:

The attached Report of Findings identifies the 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,

Kandis Gomez, AA

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

Survey Process Employed:

| | |
|-----------------------------------|---|
| Administrative Review Start Date: | August 31, 2018 |
| Contact: | <u>Community Options, Inc.</u> Hector Johnson, State Director |
| On-site Entrance Conference Date: | September 04, 2018 |
| Present: | <u>Community Options, Inc.</u> Hector Johnson, Executive Director Angelita Chavez, Associate Executive Director Dennise Mirabal, Quality Assurance Coordinator/DSP <u>DOH/DHI/QMB</u> Kandis Gomez, AA, Team Lead/Healthcare Surveyor Michele Beck, Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor |
| Exit Conference Date: | September 06, 2018 |
| Present: | <u>Community Options, Inc.</u> Noemi Olivas, Director of Program Services/Service Coordinator/DSP Supervisor Hector Johnson, Executive Director Angelita Chavez, Associate Executive Director Dennise Mirabal, Quality Assurance Coordinator/DSP <u>DOH/DHI/QMB</u> Kandis Gomez, AA, Team Lead/Healthcare Surveyor Debbie Russell, BS, Healthcare Surveyor Michele Beck, Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor <u>DDSD Regional Office</u> Angie Brooks, Regional Director (SW Region) |
| Administrative Locations Visited | 1 |
| Total Sample Size | 10 1 - <i>Jackson</i> Class Members 9 - <i>Non-Jackson</i> Class Members 7 - Supported Living 2 - Family Living 1 - Adult Habilitation 9 - Customized Community Supports 3 - Community Integrated Employment Services |
| Total Homes Visited | 6 |
| ❖ Supported Living Homes Visited | 4 <i>Note: The following Individuals share a SL residence:</i> ➤ #1, 5, 8 ➤ #4, 9 |

| | |
|---|--|
| ❖ Family Living Homes Visited | 2 |
| Persons Served Records Reviewed | 10 |
| Persons Served Interviewed | 7 |
| Persons Served Observed (process) | 1 (one individual chose not to participate in the interview process) |
| Persons Served Not Seen and/or Not Available | 2 |
| Direct Support Personnel Interviewed | 14 |
| Direct Support Personnel Records Reviewed | 118 |
| Substitute Care/Respite Personnel Records Reviewed | 3 |
| Service Coordinator Records Reviewed | 1 |
| Administrative Interviews | 2 |

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
 - Individual Service Plans
 - Progress on Identified Outcomes
 - Healthcare Plans
 - Medication Administration Records
 - Medical Emergency Response Plans
 - Therapy Evaluations and Plans
 - Healthcare Documentation Regarding Appointments and Required Follow-Up
 - Other Required Health Information
- Internal Incident Management Reports and System Process / 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 DDS 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 DDS Office.

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

Instructions for Completing Agency POC:

Required Content

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

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

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

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

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

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

- Details about how and when Individual Served, agency personnel and administrative and service delivery site files are audited by agency personnel to ensure they contain required documents;
- Information about how medication administration records are reviewed to verify they contain all required information before they are distributed to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (LOC) packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
 - a. Electronically at AmandaE.Castaneda@state.nm.us (**preferred method**)
 - b. Fax to 575-528-5019, or
 - c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”
 - a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45-business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
 - b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.
 - c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
 - d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
 - e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

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

1. Your internal documents are due within a maximum of 45-business days of receipt of your Report of Findings.

2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If documents containing HIPAA Protected Health Information (PHI) documents must be submitted through S-Comm (Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to e-mails.
3. All submitted documents must be annotated; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDS 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 or a 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 as Condition of Participation Level deficiencies. 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. No matter the number of times a Condition of Participation Level deficiency is cited (one consumer or the entire sample), the Tag in which the deficiency falls is cited at the Condition of Participation Level. 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
- **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 Requirements. (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 that no deficiencies at the Condition of Participation Level were found. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of *Compliance*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

Partial-Compliance with Standard Level Tags:

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

1. Your Report of Findings includes 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 and 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: Community Options, Inc. - Southwest Region
Program: Developmental Disabilities Waiver
Service: 2007: Supported Living, Adult Habilitation
 2012: Supported Living, Family Living, Customized Community Supports, Community Integrated Employment Services
 2018: Customized Community Supports, Community Integrated Employment Services
Survey Type: Routine
Survey Date: August 31 – September 6, 2018

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
|--|--|---|-----------|
| Service Domain: Service Plans: ISP Implementation - Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan. | | | |
| Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency) | Standard Level Deficiency | | |
| <p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities' division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive</p> | <p>Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan for 1 of 10 individuals.</p> <p>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Administrative Files Reviewed:</p> <p>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #8</p> <ul style="list-style-type: none"> According to the Live Outcome; Action Step for "...will wipe face during meals" is to be completed daily. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/2018 - 7/2018. | <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> | <p> </p> |

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| <p>supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 Chapter 6: Individual Service Plan (ISP) 6.8 ISP Implementation and Monitoring: All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.</p> <p>Chapter 20: Provider Documentation and Client Records</p> | <p>Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #8</p> <ul style="list-style-type: none"> • According to the Work/Learn Outcome; Action Step for "...will take at least 2 photos a week" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2018. | | |
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| <p>20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:</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 maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with | | | |
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DSP while providing services in the community.
7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.

| Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation) | Standard Level Deficiency | | |
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| <p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities' division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and</p> | <p>Based on residential record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan for 2 of 9 individuals.</p> <p>As indicated by Individual's ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #8</p> <ul style="list-style-type: none"> • None found regarding: Live Outcome/Action Step: "...will wash his hands daily" for 9/1-3/2018. Action step is to be completed daily. Document maintained by the provider was blank. (Date of home visit: 9/4/2018) <p>Individual #9</p> <ul style="list-style-type: none"> • According to the Live Outcome; Action Step for "...will participate in pain relieving activities" is to be completed 1 time per day. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/1- 3/2018. (Date of home visit: 9/4/2018) | <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> |

purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018
Chapter 6: Individual Service Plan (ISP)
6.8 ISP Implementation and Monitoring: All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.

Chapter 20: Provider Documentation and Client Records

20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:
1. Client records must contain all documents

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| <p>essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.</p> <p>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.</p> <p>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>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.</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> | | | |
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| Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements | Standard Level Deficiency | | |
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| <p>7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:</p> <p>C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed.</p> <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 | <p>Based on record review, the Agency did not complete written status reports as required for 2 of 10 individuals receiving Living Care Arrangements and Community Inclusion.</p> <p>Nursing Semi-Annual / Quarterly Reports:</p> <ul style="list-style-type: none"> • Individual #6 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 3/28/2017 - 9/28/2017; Date Completed: 10/18/2017; ISP meeting held on 5/25/2017) • Individual #9 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 10/30/2017 - 4/30/2018; Date Completed: 5/30/2018; ISP meeting held on 2/9/2018) | <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> |

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| <p>essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.</p> <p>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.</p> <p>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>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.</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>Chapter 19: Provider Reporting Requirements: 19.5 Semi-Annual Reporting: The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to</p> | | | |
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| <p>professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDS for QA activities.</p> <p>Semi-annual reports are required as follows:</p> <ol style="list-style-type: none"> 1. DD Waiver Provider Agencies, except AT, EMSP, Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports. 2. A Respite Provider Agency must submit a semi-annual progress report to the CM that describes progress on the Action Plan(s) and Desired Outcome(s) when Respite is the only service included in the ISP other than Case Management, for an adult age 21 or older. 3. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days). 4. The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting. 5. Semi-annual reports must contain at a minimum written documentation of: <ol style="list-style-type: none"> a. the name of the person and date on each page; b. the timeframe that the report covers; c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering; d. a description of progress towards Desired Outcomes in the ISP related to the service provided; e. a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing); f. significant changes in routine or staffing if | | | |
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applicable;
g. unusual or significant life events, including significant change of health or behavioral health condition;
h. the signature of the agency staff responsible for preparing the report; and
i. any other required elements by service type that are detailed in these standards.

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
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| Service Domain: Qualified Providers - The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver. | | | |
| Tag # 1A20 Direct Support Personnel Training | Standard Level Deficiency | | |
| <p>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 hazardous chemicals).</p> | <p>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 1 of 118 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 (#540) | <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> |

- f. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using EPR. Agency DSP and DSS shall maintain certification in a DDSD-approved system if any person they support has a BCIP that includes the use of EPR.
 - g. Complete and maintain certification in a DDSD-approved medication course if required to assist with medication delivery.
 - h. Complete training regarding the HIPAA.
2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings and be on shift with a DSP who has completed the relevant IST.

17.1.2 Training Requirements for Service Coordinators (SC): Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports.

- 1. A SC must successfully:
 - a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported, and as outlined in the 17.10 Individual-Specific Training below.
 - b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14.
 - c. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.
 - d. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines.
 - e. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals).

f. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using emergency physical restraint. Agency SC shall maintain certification in a DDSD-approved system if a person they support has a Behavioral Crisis Intervention Plan that includes the use of emergency physical restraint.

g. Complete and maintain certification in AWMD if required to assist with medications.

h. Complete training regarding the HIPAA.

2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings.

| Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry | Standard Level Deficiency | | |
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| <p>NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date</p> | <p>Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 3 of 121 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:</p> <p>Direct Support Personnel (DSP):</p> <ul style="list-style-type: none"> • #512 – Date of hire 10/10/2017, completed 10/24/2017. • #578 – Date of hire 1/16/2018, completed 3/12/2018. • #579 – Date of hire 8/21/2017, completed 8/22/2017. | <p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> → </p> | <p> </p> |

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| <p>of birth, social security number, and other appropriate identifying information required by the registry.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.</p> <p>F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.</p> | | | |
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| <p>5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities.</p> <p>Appendix B GER Requirements: DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting:</p> <p>1. Effective immediately, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau.</p> <p>2. No alternative methods for reporting are permitted.</p> <p><u>The following events need to be reported in the Therap GER:</u></p> <ul style="list-style-type: none"> - Emergency Room/Urgent Care/Emergency Medical Services - Falls Without Injury - Injury (including Falls, Choking, Skin Breakdown and Infection) - Law Enforcement Use - Medication Errors - Medication Documentation Errors - Missing Person/Elopement - Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission - PRN Psychotropic Medication - Restraint Related to Behavior - Suicide Attempt or Threat <p><u>Entry Guidance:</u> Provider Agencies must complete the following sections of the GER with detailed information: profile information, event information, other event information, general information, notification, actions taken or planned, and the review follow up comments section. Please attach any pertinent external documents such as discharge summary,</p> | <ul style="list-style-type: none"> • General Events Report (GER) indicates on 5/9/2018 the Individual foot was swollen and taken to ER. (Injury/ER Visit). GER was approved 5/14/2018. | | |
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medical consultation form, etc. Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
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| Service Domain: Health and Welfare - The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner. | | | |
| Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up (Upheld by IRF) | Condition of Participation Level Deficiency | | |
| <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</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> <p>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;</p> <p>b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy;</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</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 provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 2 of 10 individuals receiving Living Care Arrangements and Community Inclusion.</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p>Annual Physical:</p> <ul style="list-style-type: none"> • Not Current (#1) <p>Pap Smear Exam:</p> <ul style="list-style-type: none"> ◦ Individual #7 - As indicated by collateral documentation reviewed, exam was completed on 7/28/2017. Follow-up was to be completed in 1 year. No evidence of follow-up found. <p><i>Note: Finding for Individual #7 upheld by IRF 12/18/2018.</i></p> <p>Mammogram Exam:</p> <ul style="list-style-type: none"> ◦ Individual #7 - As indicated by collateral documentation reviewed, exam was completed on 5/22/2017. Follow-up was to be completed in 1 year. No evidence of follow-up found. | <p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p> | |

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| <p>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 20: Provider Documentation and Client Records: 20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to</p> | <p><i>Note: Finding for Individual #7 upheld by IRF 12/18/2018.</i></p> | | |
|--|---|--|--|

adhere to the following:

1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.
2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable.
3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.
4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.
5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.
6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.
7. All records pertaining to JCMs must be retained permanently and must be made available to DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.

20.5.3 Health Passport and Physician

Consultation Form: All Primary and Secondary Provider Agencies must use the Health Passport

and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form. The Physician Consultation form contains a list of all current medications.

**Chapter 10: Living Care Arrangements (LCA)
Living Supports-Supported Living: 10.3.9.6.1
Monitoring and Supervision**

4. Ensure and document the following:
 - a. The person has a Primary Care Practitioner.
 - b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist.
 - c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist.
 - d. The person receives a hearing test as recommended by a licensed audiologist.
 - e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist.
5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine).

**10.3.10.1 Living Care Arrangements (LCA)
Living Supports-IMLS:**

10.3.10.2 General Requirements: 9 . Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and annual

dental checkup by a licensed dentist).

Chapter 13 Nursing Services: 13.2.3 General Requirements:

1. Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information.

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015

Chapter 6 (CCS) 3. Agency Requirements:

G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 7 (CIHS) 3. Agency Requirements:

E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 11 (FL) 3. Agency Requirements:

D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012

III. Requirement Amendments(s) or

Clarifications:

A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.

H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
|--|--|---|-----------|
| Service Domain: Medicaid Billing/Reimbursement - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. | | | |
| Tag # IS30 Customized Community Supports Reimbursement | Standard Level Deficiency | | |
| <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 | <p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 1 of 9 individuals.</p> <p>Individual #8 June 2018</p> <ul style="list-style-type: none"> • The Agency billed 108 units of Customized Community Supports (group) (T2021 HB U7) from 6/18/2018 through 6/24/2018. Documentation received accounted for 104 units. <i>(Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)</i> • The Agency billed 108 units of Customized Community Supports (group) (T2021 HB U7) from 6/25/2018 through 6/30/2018. Documentation received accounted for 96 units. <i>(Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)</i> <p>July 2018</p> <ul style="list-style-type: none"> • The Agency billed 48 units of Customized Community Supports (group) (T2021 HB U7) from 7/30/2018 through 7/31/2018. Documentation received accounted for 42 units. <i>(Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)</i> | <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> → </p> | <p> </p> |

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:

- 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.

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015

CHAPTER 6 (CCS) 4. REIMBURSEMENT

A. Required Records: Customized Community Supports Services Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. Customized Community Supports Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are

required to comply with the New Mexico Human Services Department Billing Regulations.

B. Billable Unit:

1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit.
2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit.
3. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group assignment.
4. The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Customized Community Supports without prior approval from DDSD.
5. The billable unit for Individual Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit.
6. The billable unit for Fiscal Management for Adult Education is one dollar per unit including a 10% administrative processing fee.
7. The billable units for Adult Nursing Services are addressed in the Adult Nursing Services Chapter.

C. Billable Activities: All DSP activities that are:

- a. Provided face to face with the individual;
- b. Described in the individual's approved ISP;
- c. Provided in accordance with the Scope of Services; and
- d. Activities included in billable services, activities or situations.

| Tag # LS26 Supported Living Reimbursement | Standard Level Deficiency | | |
|--|--|---|--|
| <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements: DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following:</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 the following for a period of at least six years | <p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 1 of 7 individuals.</p> <p>Individual #4 May 2018</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Supported Living (T2033 U1) on 5/21/2018. Documentation received accounted for .5 units. <i>(Note: Void/Adjust provided during the on-site survey. Provider complete POC for ongoing QA/QI.)</i> | <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> → </p> | |

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| <p>from the payment date:</p> <ul style="list-style-type: none"> 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. <p>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.</p> <p>21.9.1 Requirements for Daily Units: For services billed in daily units, Provider Agencies must adhere to the following:</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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. <p>21.9.2 Requirements for Monthly Units: For services billed in monthly units, a Provider Agency must adhere to the following:</p> <ul style="list-style-type: none"> 1. A month is considered a period of 30 calendar days. 2. At least one hour of face-to-face billable | | | |
|--|--|--|--|

| | | | |
|--|--|--|--|
| <p>services shall be provided during a calendar month where any portion of a monthly unit is billed.</p> <p>3. Monthly units can be prorated by a half unit.</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>2. Services that last in their entirety less than eight minutes cannot be billed.</p> | | | |
|--|--|--|--|

Date: December 19, 2018

To: Hector Johnson, Executive Director
Provider: Community Options, Inc.
Address: 2500 Missouri
State/Zip: Las Cruces, New Mexico 88011

E-mail Address: Hector.Johnson@comop.org

Region: Southwest Region
Survey Date: August 31 - September 6, 2018
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2007:** Supported Living, Adult Habilitation
2012: Supported Living, Family Living, Customized Community Supports, Community Integrated Employment Services
2018: Customized Community Supports, Community Integrated Employment Services

Survey Type: Routine Survey

RE: Request for an Informal Reconsideration of Findings

Dear Mr. Johnson,

Your request for a Reconsideration of Findings was received on November 2, 2018. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A08.2

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. During the on-site survey the agency was given the opportunity to present any information to dispute this finding. As of the end of survey, September 6, 2018, no documentation to dispute the requirement for a pap smear and mammogram for Individual #7 was provided. Also, as stated in the IRF, the Decision Consultation Form was "overlooked by the agency and was not in the file for review during the audit". Although this is a valid citation, please use the documentation provided during the IRF as evidence of correction for the Plan of Correction. The remaining citations noted in this tag were not disputed.

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

Thank you.
Respectfully,

Crystal Lopez-Beck

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

Q.19.2.DDW.D3124.3.RTN.12.18.353

Date: January 7, 2019

To: Hector Johnson, Executive Director
Provider: Community Options, Inc.
Address: 2500 Missouri
State/Zip: Las Cruces, New Mexico 88011

E-mail Address: Hector.Johnson@comop.org

Region: Southwest Region
Survey Date: August 31 - September 6, 2018
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2007:** Supported Living, Adult Habilitation
2012: Supported Living, Family Living, Customized Community Supports, Community Integrated Employment Services
2018: Customized Community Supports, Community Integrated Employment Services

Survey Type: Routine Survey

Dear Mr. Johnson;

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.D3124.3.RTN.09.19.007