Date:	December 7, 2018
To:	Patsy E. Tarin, Executive Director
Provider:	Campo Behavioral Health, L.L.C.
Address:	424 N. Mesilla Street
City, State, Zip:	Las Cruces, New Mexico 88005
E-mail Address:	patsy@campobh.com
Region:	Southwest
Survey Date:	September 28 – October 4, 2018
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2012 & 2018:*** Supported Living, Customized Community Supports
Survey Type:	Routine
Team Leader:	Monica Valdez, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Member:	Debbie Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Amanda Castaneda, MPA, Healthcare Surveyor / Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau; Lucio Hernandez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Beverly Estrada, ADN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Patsy E. Tarin;

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

Determination of Compliance:

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

Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags: This determination is based on noncompliance with one to five (1 – 5) Condition of Participation Level Tags *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # 1A20 Direct Support Personnel Training
- Tag # 1A22 Agency Personnel Competency

The following tags are identified as Standard Level:

- Tag # 1A08.1 Administrative and Residential Case File: Progress Notes
- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements
- Tag # LS14.1 Residential Service Delivery Site Case File (Other Required Documentation)
- Tag # 1A43.1 General Events Reporting – Individual Reporting
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # LS25 Residential Health and Safety (Supported Living and Family Living)
- Tag # IS30 Customized Community Supports Reimbursement
- Tag # LS26 Supported Living Reimbursement

Plan of Correction:

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

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (Attachment A) for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

Corrective Action for Current Citation:

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

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done on an ongoing basis? (i.e. file reviews, etc.)
- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position within your agency)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

Submission of your Plan of Correction:

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

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

1. **Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator 1170 North Solano Suite D Las Cruces, New Mexico 88001**

2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

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

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

Billing Deficiencies:

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

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

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

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

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

Request for Informal Reconsideration of Findings (IRF):

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

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

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,

Monica Valdez, BS

Monica Valdez, BS
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	September 28, 2018
Contact:	**Campo Behavioral Health, L.L.C.** Patsy Tarin, Executive Director **DOH/DHI/QMB** Monica Valdez, BS, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	October 1, 2018
Present:	**Campo Behavioral Health, L.L.C.** Patsy Tarin, Executive Director Mayra Enriquez, Service Coordinator Roberta Harris, Service Coordinator Rudy DeLaO, Trainer Christopher Molina, Medical Assistant Kristina Rueckner, Assistant Director / Registered Nurse **DOH/DHI/QMB** Monica Valdez, BS, Team Lead/Healthcare Surveyor Amanda Castaneda, MPA, Healthcare Surveyor/Plan of Correction Coordinator Debbie Russell, BS, Healthcare Surveyor Lucio Hernandez, AA, Healthcare Surveyor Beverly Estrada, ADN, Healthcare Surveyor
Exit Conference Date:	October 4, 2018
Present:	**Campo Behavioral Health, L.L.C.** Patsy Tarin, Executive Director Kristina Rueckner, Assistant Director/Registered Nurse **DOH/DHI/QMB** Monica Valdez, BS, Healthcare Surveyor Amanda Castaneda, MPA, Healthcare Surveyor/Plan of Correction Coordinator Lucio Hernandez, AA, Healthcare Surveyor Beverly Estrada, AND, Healthcare Surveyor **DDSD – Southwest Regional Office** Dave Brunson, Generalist
Administrative Locations Visited	1
Total Sample Size	7 0 - *Jackson* Class Members 7 - Non-*Jackson* Class Members 7 - Supported Living 7 - Customized Community Supports - Individual
Total Homes Visited	5
❖ Supported Living Homes Visited	5

Note: The following Individuals share a SL residence:

- #1, 3
- #6, 7

Persons Served Records Reviewed	7
Persons Served Interviewed	4
Persons Served Observed	2 (Two Individuals chose not to participate in the interview process)
Persons Served Not Seen and/or Not Available	1
Direct Support Personnel Interviewed	12
Direct Support Personnel Records Reviewed	60
Service Coordinator Records Reviewed	3
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 DDSD Regional Office for purposes of contract management or the Internal Review Committee [IRC] for possible actions or sanctions).

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

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

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

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

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

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

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

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

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

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

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

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

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

Attachment B

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

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Assurance system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

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

Conditions of Participation (CoPs)

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

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

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

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

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

<u>Service Domain: Qualified Providers -</u> *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*

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

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

- **1A22 -** Agency Personnel Competency
- **1A37 –** Individual Specific Training

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

Service Domain: Health, Welfare and Safety - *The State, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*

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

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

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.

Attachment D

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 CoPs	0 to 5 CoPs	6 or more CoPs
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
"Non-Compliance"						**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.
"Partial Compliance with Standard Level tags and Condition of Participation Level Tags"					**Any Amount** of Standard Level Tags, plus **1 to 5** Conditions of Participation Level tags.		
"Partial Compliance with Standard Level tags"			**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.			
"Compliance"	**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: **Campo Behavioral Health, L.L.C. - Southwest**
Program: Developmental Disabilities Waiver
Service: ***2012 & 2018:*** Supported Living, Customized Community Supports
Survey Type: Routine
Survey Date: **September 28 – October 4, 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 # 1A08.1 Administrative and Residential Case File: Progress Notes	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs,	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 4 of 7 Individuals. Review of the Agency individual case files revealed the following items were not found: **Supported Living Individual Intensive Behavioral Services Notes/Daily Contact Logs:** • Individual #1 - Review of progress notes indicate separate progress notes were not kept for Individual Intensive Behavioral Support services for 6/1 – 30, 2018; 7/1 – 31, 2018; 8/1 – 31, 2018. • Individual #2 - Review of progress notes indicate separate progress notes were not kept for Individual Intensive Behavioral Support services for 6/1 – 30, 2018; 7/1 – 16, 2018. • Individual #5 - Review of progress notes indicate separate progress notes were not kept for Individual Intensive Behavioral Support services for 6/1 – 30, 2018; 7/1 – 31, 2018; 8/1 – 31, 2018.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015** **Chapter 6 (CCS) 3. Agency Requirements: 4. Reimbursement A. Record Requirements 1.** ...Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record... **Chapter 7 (CIHS) 3. Agency Requirements: 4. Reimbursement A. 1....**Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the	• Individual #7 - Review of progress notes indicate separate progress notes were not kept for Individual Intensive Behavioral Support services for 6/1 – 30, 2018; 7/1 – 31, 2018; 8/1 – 31, 2018.		

billable time spent with an individual shall be kept on the written or electronic record... **Chapter 11 (FL) 3. Agency Requirements: 4. Reimbursement A. 1....**Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...			

Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	Standard Level Deficiency		
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: 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. Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:	Based on record review, the Agency did not complete written status reports as required for 1 of 7 individuals receiving Living Care Arrangements and Community Inclusion. **Nursing Semi-Annual / Quarterly Reports:** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Semi-Annual Report 6/2017 - 11/2017; Date Completed: 12/20/2017; ISP meeting held on 11/21/2017).*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **Chapter 19: Provider Reporting Requirements: 19.5 Semi-Annual Reporting:** The semi-annual report provides status updates			

to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDSD for QA activities. Semi-annual reports are required as follows: 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: a. the name of the person and date on each page; b. the timeframe that the report covers; c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering; d. a description of progress towards Desired Outcomes in the ISP related to the service provided; e. a description of progress toward any service			

specific or treatment goals when applicable (e.g. health related goals for nursing); f. significant changes in routine or staffing if applicable; g. unusual or significant life events, including significant change of health or behavioral health condition; h. the signature of the agency staff responsible for preparing the report; and i. any other required elements by service type that are detailed in these standards.			

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare requirements)	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 2 of 7 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **Annual ISP:** • Not current (#3) **Medical Emergency Response Plans:** • Allergies (#4)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form. The Physician Consultation form contains a list of all current medications. Requirements for the Health Passport and Physician Consultation form are: 2. The Primary and Secondary Provider Agencies must ensure that a current copy of the Health Passport and Physician Consultation forms are printed and available at all service delivery sites. Both forms must be reprinted and placed at all service delivery sites each time the e-CHAT is updated for any reason and whenever there is a change to contact information contained in the IDF. **Chapter 13: Nursing Services: 13.2.9 Healthcare Plans (HCP):** 1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim			

ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. 2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary **13.2.10 Medical Emergency Response Plan (MERP):** 1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP. 2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.			

Tag # LS14.1 Residential Service Delivery Site Case File (Other Required Documentation)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 7 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **Behavior Crisis Intervention Plan:** • Not Found (#2)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) 3. Agency Requirements** C. Residence Case File: The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Qualified Providers - *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A20 Direct Support Personnel Training	**Condition of Participation Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 17: Training Requirements:** The purpose of this chapter is to outline requirements for completing, reporting and documenting DDSD training requirements for DD Waiver Provider Agencies as well as requirements for certified trainers or mentors of DDSD Core curriculum training. **17.1 Training Requirements for Direct Support Personnel and Direct Support Supervisors:** Direct Support Personnel (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports. 1. DSP/DSS must successfully: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in 17.10 Individual-Specific Training below. b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14 c. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements d. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. e. Complete relevant training in accordance with OSHA requirements (if job involves exposure to	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not ensure Orientation and Training requirements were met for 11 of 60 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: **Assisting with Medication Delivery** • Expired (#505, 524, 538, 547, 559) **CPR** • Expired (#504, 510, 546, 555, 556, 557, 559) **First Aid** • Expired (#504, 510, 546, 555, 556, 557, 559)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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

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

Tag # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 13: Nursing Services** **13.2.11 Training and Implementation of Plans:** 1. RNs and LPNs are required to provide Individual Specific Training (IST) regarding HCPs and MERPs. 2. The agency nurse is required to deliver and document training for DSP/DSS regarding the healthcare interventions/strategies and MERPs that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee as described in Chapter 17.10 Individual-Specific Training. **Chapter 17: Training Requirement** **17.10 Individual-Specific Training:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 2 of 12 Direct Support Personnel. **When DSP were asked if the Individual had a Positive Behavioral Supports Plan (PBSP), have you been trained on the PBSP and what the plan covered, the following was reported:** • DSP #522 stated, "I'm not familiar with the plan." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #4) **When DSP were asked if the Individual had Medical Emergency Response Plans and where could they be located, the following was reported:** • DSP #550 stated, "Falls, Seizures, Aspiration." A s indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for Neuro/Shunt. (Individual #3) **When DSP were asked if they received training on the Individual's Physical Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #522 stated, "No." According to the Individual Specific Training Section of the ISP,	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported. 1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends. 2. IST for therapy-related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher. 3. The competency level of the training is based on the IST section of the ISP. 4. The person should be present for and involved in IST whenever possible. 5. Provider Agencies are responsible for tracking of IST requirements.	the Individual requires a Physical Therapy Plan. (Individual #4) **When DSP were asked if they received training on the Individual's Speech Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #522 stated, "No." According to the Individual Specific Training Section of the ISP the Individual requires a Speech Therapy Plan. (Individual #4)		

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

Tag # 1A43.1 General Events Reporting - Individual Reporting	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 19: Provider Reporting Requirements:** **19.2 General Events Reporting (GER):** The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows: 1. DD Waiver Provider Agencies approved to provide Customized In- Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use GER in the Therap system. 2. DD Waiver Provider Agencies referenced above are responsible for entering specified information into the GER section of the secure website operated under contract by Therap according to the GER Reporting Requirements in Appendix B GER Requirements. 3. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap. 4. GER does not replace a Provider Agency's obligations to report ANE or other reportable incidents as described in Chapter 18: Incident	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 6 of 7 individuals. **The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within 2 business days:** Individual #1 • General Events Report (GER) indicates on 5/9/2018 the Individual was found on the floor of her bedroom (Injury). GER was approved on 5/18/2018. • General Events Report (GER) indicates on 5/20/2018 the Individual was taken to urgent care (Hospital). GER was approved on 5/23/2018. • General Events Report (GER) indicates on 6/4/2018 the Individual was taken to the emergency room (Hospital). GER was approved on 6/15/2018. • General Events Report (GER) indicates on 6/9/2018 the Individual was outside when she lost her balance and fell, and staff treated her scrapes (Injury). GER was approved on 6/13/2018. • General Events Report (GER) indicates on 7/13/2018 the Individual was found on the floor of her bedroom during the middle of the night (Fall Without Injury). GER was approved on 7/18/2018.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Management System. 5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities. **Appendix B GER Requirements**: DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting: 1. Effective immediately, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau. 2. No alternative methods for reporting are permitted. **The following events need to be reported in the Therap GER:** - Emergency Room/Urgent Care/Emergency Medical Services - Falls Without Injury - Injury (including Falls, Choking, Skin Breakdown and Infection) - Law Enforcement Use - Medication Errors - Medication Documentation Errors - Missing Person/Elopement - Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission - PRN Psychotropic Medication - Restraint Related to Behavior - Suicide Attempt or Threat Entry Guidance: Provider Agencies must complete the following sections of the GER with detailed information: profile information, event information, other event information, general information, notification, actions taken or planned, and the review follow up comments	Individual #2 • General Events Report (GER) indicates on 6/5/2018 the Individual was taken to urgent care (Hospital). GER was approved on 6/15/2018. • General Events Report (GER) indicates on 8/20/2018 the Individual left his home and did not return after an hour of his alone time and police were contacted (Elopement and Law Enforcement). GER was approved on 9/11/2018. • General Events Report (GER) indicates on 9/12/2018 the Individual left his house and did not return after an hour his alone time and police were contacted (Elopement and Law Enforcement). GER was approved on 9/17/2018. Individual #3 • General Events Report (GER) indicates on 5/8/2018 the Individual toppled out of her chair and onto the floor bumping her forehead on the tile (Injury). GER was approved on 5/17/2018. • General Events Report (GER) indicates on 5/9/2018 the Individual became agitated and was assisted with a PRN medication per nurse approval (PRN Psychotropic Use). GER was approved on 5/14/2018. • General Events Report (GER) indicates on 6/1/2018 the Individual became agitated and was assisted with an approved PRN medication (PRN Psychotropic Use). GER was approved on 6/6/2018. • General Events Report (GER) indicates on 6/3/2018 the Individual was having		

section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.	challenging behaviors and was assisted with a PRN medication approved by the nurse (PRN Psychotropic Use). GER was approved on 6/14/2018. • General Events Report (GER) indicates on 6/17/2018 the Individual was having behaviors and was assisted with a PRN medication approved by the nurse (PRN Psychotropic Use). GER was approved on 6/21/2018. • General Events Report (GER) indicates on 6/23/2018 the Individual was having challenging behaviors and was assisted with a PRN medication approved by the nurse (PRN Psychotropic Use). GER was approved on 6/27/2018. • General Events Report (GER) indicates on 7/14/2018 the Individual was squatting on the floor when her sock slipped causing her to land on her bottom and smack her right elbow on the floor (Fall Without Injury). GER was approved on 7/19/2018. Individual #5 • General Events Report (GER) indicates on 7/6/2018 the Individual was walking backwards and tripped and fell on her bottom (Fall Without Injury). GER was approved on 7/25/2018. Individual #6 • General Events Report (GER) indicates on 6/15/2018 the Individual became upset and started having challenging behaviors. Staff called 911 and the individual was transported to the hospital (Law Enforcement and Hospital). GER was approved on 6/22/2018.		

	• General Events Report (GER) indicates on 7/3/2018 the Individual toppled out of her chair and onto the floor bumping her forehead on the tile (PRN Psychotropic Use). GER was approved on 7/6/2018. • General Events Report (GER) indicates on 7/6/2018 the Individual became escalated when she arrived at home and was assisted with a PRN medication approve by the nurse (PRN Psychotropic Use). GER was approved on 7/11/2018. • General Events Report (GER) indicates on 8/7/2018 the Individual became upset, screaming and yelling and was assisted with a PRN medication approved by the nurse (PRN Psychotropic Use). GER was approved on 8/14/2018. • General Events Report (GER) indicates on 8/25/2018 the Individual called 911 and was transported to the hospital. Staff arrived at the hospital and the individual could not be located, so the police were contacted. (Hospital and Law Enforcement Involvement). GER was approved on 9/3/2018. • General Events Report (GER) indicates on 8/28/2018 the Individual was bitten on her finger by her housemate and was taken to urgent care (Injury and Hospital). GER was approved on 8/31/2018. • General Events Report (GER) indicates on 8/30/2018 the Individual eloped and was found by police (Elopement and Law Enforcement). GER was approved on 9/6/2018. Individual #7		

	• General Events Report (GER) indicates on 7/17/2018 the Individual was having challenging behaviors and attacked staff. MANDT was used for about 3 seconds and the individual was then assisted with a PRN medication (Restraint and PRN Psychotropic Use). GER was approved on 7/20/2018. • General Events Report (GER) indicates on 8/1/2018 the Individual was having challenging behavior and was assisted with a PRN medication approved by the nurse (PRN Psychotropic Use). GER was approved on 8/8/2018.		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Health and Welfare **-** *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 3 Safeguards: 3.1.1 Decision Consultation Process (DCP):** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: 1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.	Based on record review and interview, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 1 of 7 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Dental Exam:** • Individual #6 - As indicated by collateral documentation reviewed, exam was completed on 6/1/2018. Follow-up was to be completed on 6/11/2018. No evidence of follow-up found. *(Note: Per Agency Nurse #564, the follow up was rescheduled on multiple dates, however Individual #6 refused the appointments. Evidence was shown of rescheduled dates).*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting. **Chapter 20: Provider Documentation and Client Records:** **20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.			

2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation			

form. The Physician Consultation form contains a list of all current medications. **Chapter 10: Living Care Arrangements (LCA) Living Supports-Supported Living: 10.3.9.6.1 Monitoring and Supervision** 4. Ensure and document the following: a. The person has a Primary Care Practitioner. b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist. c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist. d. The person receives a hearing test as recommended by a licensed audiologist. e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist. 5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine). **10.3.10.1 Living Care Arrangements (LCA) Living Supports - IMLS: 10.3.10.2 General Requirements:** 9 . Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and annual dental checkup by a licensed dentist). **Chapter 13 Nursing Services: 13.2.3 General Requirements:** 1. Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information. Developmental Disabilities (DD) Waiver Service			

Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **Chapter 6 (CCS) 3. Agency Requirements:** G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 7 (CIHS) 3. Agency Requirements:** E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 11 (FL) 3. Agency Requirements:** D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012** **III. Requirement Amendments(s) or Clarifications:** A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.			

Tag # LS25 Residential Health and Safety (Supported Living & Family Living)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 10: Living Care Arrangements (LCA)** **10.3.6 Requirements for Each Residence:** Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence: 1. has basic utilities, i.e., gas, power, water, and telephone; 2. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher; 3. has a general-purpose first aid kit; 4. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift; 5. has water temperature that does not exceed a safe temperature (1100 F); 6. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP; 7. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy; 8. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 9. supports environmental modifications and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; 10. has or arranges for necessary equipment for bathing and transfers to support health and	Based on record review and / or observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 1 of 5 Living Care Arrangement residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Carbon monoxide detectors (#4) Water temperature in home does not exceed safe temperature (110^0 F): • Water temperature in home measured 112.1^0 F (#4) *Note: The following Individuals share a residence:* ➢ #1, 3 ➢ #6, 7	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

safety with consultation from therapists as needed; 11. has the phone number for poison control within line of site of the telephone; 12. has general household appliances, and kitchen and dining utensils; 13. has proper food storage and cleaning supplies; 14. has adequate food for three meals a day and individual preferences; and 15. has at least two bathrooms for residences with more than two residents. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) Living Supports - Family Living Agency Requirements G. Residence Requirements for Living Supports- Family Living Services:** 1. Family Living Services providers must assure that each individual's residence is maintained to be clean, safe and comfortable and accommodates the individuals' daily living, social and leisure activities. In addition, the residence must: a. Maintain basic utilities, i.e., gas, power, water and telephone; b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; c. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system; d. Have a general-purpose first aid kit; e. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;			

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

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & 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**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and h. the nature of services. 3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer. 4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years	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 7 individuals. Individual #2 June 2018 • The Agency billed 159 units of Customized Community Supports (Individual) (H2021 HB U1) from 6/3/2018 through 6/9/2018. Documentation received accounted for 145 units. *(Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 139 units of Customized Community Supports (Individual) (H2021 HB U1) from 6/24/2018 through 6/30/2018. Documentation received accounted for 107 units. *(Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* July 2018 • The Agency billed 154 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/8/2018 through 7/14/2018. Documentation received accounted for 153 units. *(Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 148 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/17/2018 through 7/21/2018.	**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?)*: →	

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	Documentation received accounted for 117 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* August 2018 • The Agency billed 134 units of Customized Community Supports (individual) (H2021 HB U1) from 8/5/2018 through 8/11/2018. Documentation received accounted for 120 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)*		

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		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and h. the nature of services. 3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer. 4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any of 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;	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. Individual #5 June 2018 • The Agency billed 48 units of Supported Living Individual Intensive Behavioral Support (H2021 HB UA) on 6/17/2018. Documentation received accounted for 8 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 42 units of Supported Living Individual Intensive Behavioral Support (H2021 HB UA) on 6/23/2018. Documentation received accounted for 40 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* July 2018 • The Agency billed 44 units of Supported Living Individual Intensive Behavioral Support (H2021 HB UA) on 7/22/2018. Documentation received accounted for 8 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 40 units of Supported Living Individual Intensive Behavioral Support (H2021 HB UA) on 7/28/2018. Documentation received accounted for 8 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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.	• The Agency billed 40 units of Supported Living Individual Intensive Behavioral Support (H2021 HB UA) on 7/29/2018. Documentation received accounted for 8 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* August 2018 • The Agency billed 24 units of Supported Living Individual Intensive Behavioral Support (H2021 HB UA) on 8/2/2018. Documentation received accounted for 20 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 44 units of Supported Living Individual Intensive Behavioral Support (H2021 HB UA) on 8/11/2018. Documentation received accounted for 8 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 34 units of Supported Living Individual Intensive Behavioral Support (H2021 HB UA) on 8/19/2018. Documentation received accounted for 32 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* • The Agency billed 48 units of Supported Living Individual Intensive Behavioral Support (H2021 HB UA) on 8/26/2018. Documentation received accounted for 0 units.		

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.	• The Agency billed 24 units of Supported Living Individual Intensive Behavioral Support (H2021 HB UA) on 8/30/2018. Documentation received accounted for 12 units. (*Note: Void/Adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)*		

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date: February 6, 2019

To: Patsy E. Tarin, Executive Director
Provider: Campo Behavioral Health, L.L.C.
Address: 424 N. Mesilla Street
City, State, Zip: Las Cruces, New Mexico 88005

E-mail Address: patsy@campobh.com

Region: Southwest
Survey Date: September 28 – October 4, 2018

Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: ***2012 & 2018:*** Supported Living, Customized Community Supports

Survey Type: Routine

Dear Patsy E. Tarin;

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.D1001.3.RTN.09.19.037