

Date: March 11, 2019

To: Konnie Kanmore, Executive Director
Provider: Absolutely You, LLC
Address: 301 Pile Street
State/Zip: Clovis, New Mexico 88101

E-mail Address: kkanmore@absolutelyyoullc.com

Region: Southeast
Routine Survey: April 20 - 26, 2018
Verification Survey: February 25 – March 7, 2019

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012:** Family Living; Customized Community Supports, Community Integrated Employment Services and Customized In-Home Supports

Survey Type: Verification

Team Leader: Amanda Castaneda, MPA, Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau

Dear Ms. Konnie Kanmore;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on April 20 - 26, 2018*.

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

Compliance: This determination is based on your agency's compliance with Condition of Participation level and Standard level requirements. Deficiencies found only affect a small percentage of the Individuals on the survey sample (*refer to Attachment D for details*). The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

The following tags are identified as Standard Level:

- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (*Not Completed at Frequency*)
- Tag # 1A43.1 General Events Reporting: Individual Reporting

However, due to the new/repeat deficiencies your agency will be required to contact your DDSD Regional Office for technical assistance and follow up and complete the Plan of Correction document attached at the end of this report. Please respond to the Plan of Correction Coordinator within 10 business days of receipt of this letter.

DIVISION OF HEALTH IMPROVEMENT

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



QMB Report of Findings – Absolutely You, LLC – Southeast – February 25 – March 7, 2019

Plan of Correction:

The attached Report of Findings identifies the new/repeat Standard Level deficiencies found during your agency's verification compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 10 business days from the receipt of this letter. The Plan of Correction must include the following:

1. Evidence your agency has contacted your DDS Regional Office for technical assistance;
2. A Plan of Correction detailing Quality Assurance/Quality Improvement processes to prevent your agency from receiving deficiencies in the future. Please use the format provided at the end of this report;
3. Documentation verifying that newly cited deficiencies have been corrected.

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction and documentation verifying correction of survey deficiencies within 10 business days of receipt of this letter to the parties below:

1. **Quality Management Bureau, Attention: 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**

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

Please call the Plan of Correction Coordinator at 575-373-5716, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Amanda Castaneda, MPA

Amanda Castaneda, MPA
Team Lead/Plan of Correction Coordinator
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	February 25, 2019
Contact:	<u>Absolutely You, LLC</u> Konnies Kanmore, Executive Director
	<u>DOH/DHI/QMB</u> Amanda Castaneda, MPA, Team Lead / Plan of Correction Coordinator
Exit Conference Date:	March 7, 2019
Present:	<u>Absolutely You, LLC</u> Ashley Park, Chief Financial Officer
	<u>DOH/DHI/QMB</u> Amanda Castaneda, MPA, Team Lead / Plan of Correction Coordinator
Total Sample Size:	14
	0 - <i>Jackson</i> Class Members 14 - Non- <i>Jackson</i> Class Members
	8 - Family Living 11 - Customized Community Supports 9 - Community Integrated Employment 4 - Customized In-Home Supports
Persons Served Records Reviewed	14
Direct Support Personnel Records Reviewed	97 (3 Service Coordinators perform dual roles as DSP)
Direct Support Personnel Interviewed during Routine Survey	17 (1 Service Coordinator was interviewed as DSP)
Service Coordinator Records Reviewed	3
Administrative Interviews	1

Administrative Processes and Records Reviewed:

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

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- 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:

1. 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;
2. 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;
1. Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
1. How accuracy in billing/reimbursement documentation is assured;
1. How health, safety is assured;
1. 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;
2. Your process for gathering, analyzing and responding to quality data indicators; and,
3. 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

1. 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.
2. Direct care issues should be corrected immediately and monitored appropriately.
3. Some deficiencies may require a staged plan to accomplish total correction.
4. 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:
 1. Electronically at AmandaE.Castaneda@state.nm.us (**preferred method**)
 2. Fax to 575-528-5019, or
 3. 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.”
 1. 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.
 2. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.
 3. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
 4. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
 5. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

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

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

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

Attachment B

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

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

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDS 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 (DDS), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

Service Domains and CoPs for Living Care Arrangements and Community Inclusion are as follows:

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

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

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

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

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

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

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Survey Report #: Q.18.3.DDW.96001747.4.VER.01.19.070

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

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):

- 1A25.1 – Caregiver Criminal History Screening
- 1A26.1 – Consolidated On-line Registry Employee Abuse Registry

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

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

- 1A08.2 – Administrative Case File: Healthcare Requirements & Follow-up
- 1A09 – Medication Delivery Routine Medication Administration
- 1A09.1 – Medication Delivery PRN Medication Administration
- 1A15.2 – Administrative Case File: Healthcare Documentation (Therap and Required Plans)

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):

- 1A05 – General Requirements / Agency Policy and Procedure Requirements
- 1A07 – Social Security Income (SSI) Payments
- 1A09.2 – Medication Delivery Nurse Approval for PRN Medication
- 1A15 – Healthcare Documentation - Nurse Availability
- 1A31 – Client Rights/Human Rights
- LS25.1 – Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

Attachment C

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

Introduction:

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

Instructions:

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

The following limitations apply to the IRF process:

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

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

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

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

QMB Determinations of Compliance

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or has no deficiencies at the Condition of Participation Level. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of *Compliance*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

Partial-Compliance with Standard Level Tags:

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

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.
2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

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

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety.

Non-Compliance:

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. There are three ways an agency can receive a determination of Non-Compliance:

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

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Standard Level Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
COP Level Tags:	0 COP	0 COP	0 COP	0 COP	1 to 5 COP	0 to 5 CoPs	6 or more COP
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
“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: Absolutely You, LLC - Southeast Region
Program: Developmental Disabilities Waiver
Service: 2012: Family Living; Customized Community Supports, Community Integrated Employment Services and Customized In-Home Supports
Survey Type: Verification
Routine Survey: April 20 – 26, 2018
Verification Survey: February 25 – March 7, 2019

Standard of Care	Routine Survey Deficiencies April 20 – 26, 2018	Verification Survey New and Repeat Deficiencies February 25 – March 7, 2019
<i>Service Domain: Service Plans: ISP Implementation – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</i>		
Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)	Standard Level Deficiency	Standard Level Deficiency
<p>NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS: Each ISP shall contain.</p> <p>A. Demographic information: The individual’s name, age, date of birth, important identification numbers (i.e., Medicaid, Medicare, social security numbers), level of care address, phone number, guardian information (if applicable), physician name and address, primary care giver or service provider(s), date of the ISP meeting (either annual, or revision), scheduled month of next annual ISP meeting, and team members in attendance.</p> <p>B. Long term vision: The vision statement shall be recorded in the individual’s actual words, whenever possible. For example, in a long term vision statement, the individual may describe him or herself living and working independently in the community.</p> <p>C. Outcomes: (1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall</p>	<p>Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 11 of 14 individuals.</p> <p>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Administrative Files Reviewed:</p> <p>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #10 20 According to the Live Outcome; Action Step for “...will practice using his serrated knife” is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2018 - 3/2018.</p> <p>Individual #11</p>	<p>New / Repeat Finding:</p> <p>Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 14 individuals.</p> <p>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #10 1. According to the Live Outcome; Action Step for “...will practice using the peeler” is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for week of 12/8 – 21, 2018.</p>

also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP.

(2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.

NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.

C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include

21 According to the Live Outcome; Action Step for "...will research a recipe" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2018.

22 According to the Live Outcome; Action Step for "...will purchase the ingredients" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

23 According to the Live Outcome; Action Step for "...will cook with assistance" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2018.

Individual #13

24 According to the Live Outcome; Action Step for "...will choose recipe" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

25 According to the Live Outcome; Action Step for "...will shop for ingredients" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

26 According to the Live Outcome; Action Step for "...will prepare food item" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #4

specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.

D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018

Chapter 6: Individual Service Plan (ISP)

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

Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.

27 According to the Live, Outcome; Action Step for "...will research dinner" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

28 According to the Live, Outcome; Action Step for "...will prepare diabetic meal" is to be completed times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

Individual #6

29 According to the Live, Outcome; Action Step for "...will research what he wants to purchase" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

Individual #8

30 According to the Live, Outcome; Action Step for "...will prepare healthy meals/snacks" is to be completed 1 times per weekly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #5

31 According to the Fun Outcome; Action Step for "...will choose an activity to host" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2018.

Individual #7

32 According to the Fun Outcome; Action Step: "...will choose a physical activity" for 1/2018 -

<p>DD Waiver Provider Agencies are required to adhere to the following:</p> <p>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.</p> <p>Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable.</p> <p>Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</p> <p>Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p>	<p>3/2018. Action step is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.</p> <p>Individual #10</p> <p>33 According to the Fun Outcome; Action Step for "...will utilize his language expansion book" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2018.</p> <p>Individual #13</p> <p>34 According to the Fun Outcome; Action Step for "...will take pictures" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 and 3/2018.</p> <p>35 According to the Fun Outcome; Action Step for "...will use pictures to add to her collage" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.</p> <p>Individual #14</p> <p>36 According to the Fun Outcome; Action Step for "...will participate in activity" is to be completed 1 time per weekly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.</p> <p>Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #3</p> <p>37 According to the Work/Learn Outcome; Action Step for "...will apply for jobs" is to be completed 2 times per month. Evidence found indicated it was not being completed at the</p>	
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required frequency as indicated in the ISP for 1/2018 – 3/2018.

Individual #5

38 According to the Work/Learn Outcome; Action Step for "...will accept and complete tasks" is to be completed 3 times per weekly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2018.

Individual #6

39 According to the Work/Learn Outcome; Action Step for "...will ask his manager for needed supplies" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

Individual #8

40 According to the Work/Learn Outcome; Action Step for "...will check inventory list" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

41 According to the Work/Learn Outcome; Action Step for "...will give list to staff" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

Individual #12

42 According to the Work/Learn Outcome; Action Step for "...will put on his vest" is to be completed each scheduled work day. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

43 According to the Work/Learn Outcome; Action Step for "...will look both ways before

entering the roadway” is to be completed each scheduled work day. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

44 According to the Work/Learn Outcome; Action Step for “...will hold his stop sign up the entire time he is in the road way” is to be completed each scheduled work day. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018.

Standard of Care	Deficiencies	Verification Survey New and Repeat Deficiencies February 25 – March 7, 2019
<p>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.</p>		
Tag # 1A43.1 General Events Reporting: Individual Reporting	Standard Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p>Chapter 19: Provider Reporting Requirements:</p> <p>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:</p> <p>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.</p> <p>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. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap.</p> <p>GER does not replace a Provider Agency's obligations to report ANE or other reportable incidents as described in Chapter 18: Incident Management System.</p> <p>GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities.</p>	<p>Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 2 of 14 individuals.</p> <p>The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within 2 business days:</p> <p>Individual #1</p> <p>1. General Events Report (GER) indicates on 9/21/2017 the Individual had skin breakdown. (Injury). GER was approved 9/26/2017.</p> <p>The following events were not reported in the General Events Reporting System as required by policy:</p> <p>Individual #6</p> <ul style="list-style-type: none"> • Documentation reviewed indicates on 12/29/2017 the Individual went to the Emergency room after being bitten by a dog, law enforcement was involved (Law Enforcement/Emergency Room). No GER was found. 	<p>New / Repeat Finding:</p> <p>Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 2 of 14 individuals.</p> <p>The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within 2 business days:</p> <p>Individual #5</p> <p>2. General Events Report (GER) indicates on 12/9/2018 the Individual was playing with the dog. (Injury). GER was approved 12/13/2018.</p> <p>Individual #13</p> <p>3. General Events Report (GER) indicates on 10/5/2018 the Individual lost balance and fell. (Injury). GER was approved 10/16/2018.</p>

Appendix B GER Requirements: DDS is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting: *Effective immediately*, DDS 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. No alternative methods for reporting are permitted.

The following events need to be reported in the Therap GER:

1. Emergency Room/Urgent Care/Emergency Medical Services
2. Falls Without Injury
3. Injury (including Falls, Choking, Skin Breakdown and Infection)
4. Law Enforcement Use
5. Medication Errors
6. Medication Documentation Errors
7. Missing Person/Elopement
8. Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission
9. PRN Psychotropic Medication
10. Restraint Related to Behavior
11. 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 section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.

Standard of Care	Routine Survey Deficiencies August 24 – 29, 2018	Verification survey New and Repeat Deficiencies February 25 – March 7, 2019
Service Domain: Service Plans: ISP Implementation – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.		
Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	Standard Level Deficiency (Modified as result of Pilot 1)	COMPLETE
Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	Standard Level Deficiency	COMPLETE
Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	Standard Level Deficiency (Modified as result of Pilot 1)	COMPLETE
Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)	Standard Level Deficiency	COMPLETE
Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	Standard Level Deficiency	COMPLETE
Tag # LS14 Residential Case File (ISP and Healthcare Requirements)	Condition of Participation Level Deficiency (Upheld as result of Pilot 1)	COMPLETE
Tag # LS14.1 Residential Case File (Other Req. Documentation)	Standard Level Deficiency	COMPLETE
Service Domain: Qualified Providers – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.		
Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency (Modified as result of Pilot 1)	COMPLETE
Tag # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency (Upheld as result of Pilot 1)	COMPLETE
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	Condition of Participation Level Deficiency (Upheld as result of Pilot 1)	COMPLETE
Tag # 1A05 General Requirements / Agency Policy and Procedure Requirements	Condition of Participation Level Deficiency (Upheld as result of Pilot 1)	COMPLETE

Tag # 1A15 Healthcare Documentation - Nurse Availability	Condition of Participation Level Deficiency <i>(Upheld as result of Pilot 1)</i>	COMPLETE
Tag # LS25 Residential Health & Safety (Supported Living & Family Living)	Standard Level Deficiency <i>(Modified as result of Pilot 1)</i>	COMPLETE
Service Domain: Medicaid Billing/Reimbursement – <i>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</i>		
Tag # IS30 Customized Community Supports Reimbursement	Standard Level Deficiency	COMPLETE
Tag #IH32 Customized In-Home Supports Reimbursement	Standard Level Deficiency	COMPLETE

Agency Plan of Correction		
Tag #	Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party	Due Date
Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)	Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →	<input type="checkbox"/>
Tag # 1A43.1 General Events Reporting: Individual Reporting	Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →	<input type="checkbox"/>

Date: April 1, 2019

To: Konnie Kanmore, Executive Director
Provider: Absolutely You, LLC
Address: 301 Pile Street
State/Zip: Clovis, New Mexico 88101

E-mail Address: kkanmore@absolutelyyoullc.com

Region: Southeast
Routine Survey: April 20 - 26, 2018
Verification Survey: February 25 – March 7, 2019

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012:** Family Living; Customized Community Supports, Community Integrated Employment Services and Customized In-Home Supports

Survey Type: Verification

Dear Ms. Konnie Kanmore;

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

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