Date: June 20, 2019

To: Doris A. Roberts, Executive Director
Provider: All Individuals First, Inc.
Address: 2101 Trinity Drive, Suite A-3
City, State, Zip: Los Alamos, New Mexico 87544

E-mail Address: allindividualsfirst@gmail.com

Region: Northeast
Survey Date: May 24 - 29, 2019
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2018:*** Customized Community Supports

Survey Type: Routine

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

Team Member: Elisa Alford, MSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Doris A. Roberts;

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 # 1A22 Agency Personnel Competency
- Tag # 1A05 General Provider Requirements/Agency Policy and Procedures Requirements
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)

The following tags are identified as Standard Level:

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

- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements
- Tag # 1A31.2 Human Right Committee Composition
- Tag # IS30 Customized Community Supports 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
1474 Rodeo Road
Santa Fe, New Mexico 87505

If you have questions and would like to speak with someone at HSD/OIG/PIU, please contact:

*Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)*
*OR*
*Jennifer Goble (Jennifer.goble2@state.nm.us)*

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

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

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

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator Amanda Castaneda at 575-373-5716 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Lora Norby,

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

## Survey Process Employed:

| | |
|---|---|
| Administrative Review Start Date: | May 24, 2019 |
| Contact: | **All Individuals First, Inc.**<br>Doris Roberts, Executive Director / Service Coordinator<br><br>**DOH/DHI/QMB**<br>Lora Norby, Team Lead/Healthcare Surveyor |
| On-site Entrance Conference Date: | May 28, 2019 |
| Present: | **All Individuals First, Inc.**<br>Doris Roberts, Executive Director / Service Coordinator<br><br>**DOH/DHI/QMB**<br>Lora Norby, Healthcare Surveyor<br>Elisa Alford, MSW, Healthcare Surveyor |
| Exit Conference Date: | May 29, 2019 |
| Present: | **All Individuals First, Inc.**<br>Doris Roberts, Executive Director / Service Coordinator<br><br>**DOH/DHI/QMB**<br>Lora Norby, Healthcare Surveyor<br>Elisa Alford, MSW, Healthcare Surveyor<br><br>**DDSD - NE Regional Office**<br>Angela Pacheco, Regional Director<br>Kelly Wright, Social and Community Coordinator |
| Administrative Locations Visited | 1 |
| Total Sample Size | 4<br><br>0 - *Jackson* Class Members<br>4 - Non-*Jackson* Class Members<br><br>4 - Customized Community Supports |
| Persons Served Records Reviewed | 4 |
| Persons Served Interviewed | 3 |
| Persons Served Not Seen and/or Not Available | 1 |
| Direct Support Personnel Interviewed | 1 |
| Direct Support Personnel Records Reviewed | 2 |
| Service Coordinator Records Reviewed | 1 |
| Administrative Interviews | 1 |

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Individual Medical and Program Case Files, including, but not limited to:
    - Individual Service Plans
    - Progress on Identified Outcomes
    - Healthcare Plans
    - Medication Administration Records
    - Medical Emergency Response Plans
    - Therapy Evaluations and Plans
    - Healthcare Documentation Regarding Appointments and Required Follow-Up
    - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- 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 | |
| Total 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** Total Tags with **75 to 100%** of the Individuals in the sample cited in any CoP Level 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** 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:** **All Individuals First, Inc. - Northeast**
**Program**: Developmental Disabilities Waiver
**Service**: **2018:** Customized Community Supports
**Survey Type**: Routine
**Survey Date:** **May 24 - 29, 2019**

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
|---|---|---|---|
| ***Service Domain: Service Plans: ISP Implementation -*** *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.* | | | |
| **Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)** | **Standard Level Deficiency** | | |
| **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.<br><br>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 | 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 3 of 4 individuals.<br><br>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:<br><br>**Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**:<br><br>Individual #2<br>• According to the Work/Learn Outcome; Action Step for "...will develop his weekly calendar of activities" 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 April 2019.<br><br>Individual #3<br>• According to the Work/Learn Outcome; Action Step for "Select 1 card from the deck to learn" is to be completed 1 time per week. Evidence found indicated it was not being completed at | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**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?)*: → | |

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| include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.<br><br>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]<br><br>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019<br>**Chapter 6: Individual Service Plan (ISP)**<br>**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.<br><br>**Chapter 20: Provider Documentation and Client Records**<br>**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 | the required frequency as indicated in the ISP for February 2019.<br><br>Individual #4<br>• According to the Work/Learn Outcome; Action Step for "With support, I will use the computer to insert the photos of the craft to complete the instructions" 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 1/2019 - 3/2019. | | |

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| 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.<br>DD Waiver Provider Agencies are required to adhere to the following:<br>8. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.<br>9. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices 10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.<br>11. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.<br>12. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.<br>13. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.<br>14. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. | | | |

| Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements | Standard Level Deficiency | | |
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| **7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:**<br>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.<br><br>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019<br>**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.<br>DD Waiver Provider Agencies are required to | Based on record review, the Agency did not complete written status reports as required for 1 of 4 individuals receiving Living Care Arrangements and Community Inclusion.<br><br>**Customized Community Supports Semi-Annual Reports:**<br>• Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/10/2018 – 4/9/2019. Semi-Annual Report 10/2/2018 - 1/4/2019; Date Completed: 1/4/2019; ISP meeting held on 1/3/2019).* | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**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?)*: → | |

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| adhere to the following:<br>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.<br>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.<br>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.<br>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.<br>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.<br>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.<br>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.<br><br>**Chapter 19: Provider Reporting Requirements: 19.5 Semi-Annual Reporting:** | | | |

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| 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.<br>Semi-annual reports are required as follows:<br>1. DD Waiver Provider Agencies, except AT, EMSP, Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports.<br>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.<br>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).<br>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.<br>5. Semi-annual reports must contain at a minimum written documentation of:<br>a. the name of the person and date on each page;<br>b. the timeframe that the report covers;<br>c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering;<br>d. a description of progress towards Desired Outcomes in the ISP related to the service provided; | | | |

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

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
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| ***Service Domain: Qualified Providers -*** *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.* | | | |
| **Tag # 1A22 Agency Personnel Competency** | **Condition of Participation Level Deficiency** | | |
| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019<br>**Chapter 13: Nursing Services 13.2.11 Training and Implementation of Plans:**<br>1. RNs and LPNs are required to provide Individual Specific Training (IST) regarding HCPs and MERPs.<br>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.<br><br>**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.<br>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.<br>Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan | After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.<br><br>Based on interview, the Agency did not ensure training competencies were met for 1 of 1 Direct Support Personnel.<br><br>**When DSP were asked, if the Individual had a Positive Behavioral Supports Crisis Plan (PBCP), the following was reported:**<br><br>• DSP #501 stated, "No." According to the Individual Specific Training Section of the ISP the Individual requires a Positive Behavioral Crisis Plan. (Individual #3)<br><br>**When DSP were asked, if they had been trained on the Individual's Health Care Plans, the following was reported:**<br><br>• DSP #501 stated, "I was not trained on Health Care Plans." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Anaphylactic Shock and Seizures. (Individual #2)<br><br>**When DSP were asked if the Individual had Medical Emergency Response Plans and where could they be located, the following was reported:**<br>• DSP #501 stated, "No." According to Electronic Comprehensive Health | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**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?)*: → | |

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| 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.<br>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.<br>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.<br>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.<br>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.<br>3. The competency level of the training is based on the IST section of the ISP. | Assessment Tool the Individual requires Medical Emergency Response Plans for: Aspiration, Reflux, Paralysis and Respiratory. (Individual #4) | | |

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| 4. The person should be present for and involved in IST whenever possible.<br>5. Provider Agencies are responsible for tracking of IST requirements.<br>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.<br>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. | | | |

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
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| ***Service Domain: Health and Welfare*** **-** *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.* | | | |
| **Tag # 1A05 General Provider Requirements/Agency Policy and Procedures Requirements** | **Condition of Participation Level Deficiency** | | |
| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018<br>**Chapter 16: Qualified Provider Agencies**<br>Qualified DD Waiver Provider Agencies must deliver DD Waiver services. DD Waiver Provider Agencies must have a current Provider Agreement and continually meet required screening, licensure, accreditation, and training requirements as well as continually adhere to the DD Waiver Service Standards. All Provider Agencies must comply with contract management activities to include any type of quality assurance review and/or compliance review completed by DDSD, the Division of Health Improvement (DHI) or other state agencies.<br><br>**NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION: Provider Application**<br>- Emergency and on-call procedures;<br>- On-call nursing services that specifically state the nurse must be available to DSP during periods when a nurse is not present. The on-call nurse must be available to make an on-site visit when information provided by the DSP over the phone indicate, in the nurse's professional judgment, a need for a face to face assessment to determine appropriate action;<br>- Incident Management Procedures that comply with the current NM Department of Health Improvement Incident Management Guide<br>- Medication Assessment and Delivery Policy and Procedure; | After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.<br><br>Based on record review and interview, the Agency did not develop, implement and / or comply with written policies and procedures to protect the physical/mental health of individuals that complies with all DDSD requirements.<br><br>**Review of Agency policies & procedures found no evidence of the following:**<br><br>• Policy and procedures regarding delegation of specific nursing functions<br><br>**When #502 was asked, does your agency have policy and procedures regarding delegation of specific nursing functions, the following was reported:**<br><br>• #502 stated, "No." | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**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?)*: → | |

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

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| NMAC.<br>j. Dispute Resolution Process, 7.26.8 NMAC.<br>k. DEPARTMENT/DDSD Training Policies and Procedures.<br>l. Fair Labor Standards Act.<br>m. New Mexico Nursing Practice Act and New Mexico Board of Nursing requirements governing certified medication aides and administration of medications, 16.12.5 NMAC.<br>n. Incident Reporting and Investigation Requirements for Providers of Community Based Services, 7.14.3 NMAC, and DHI/DEPARTMENT Incident Management System Policies and Procedures.<br>o. DHI/DEPARTMENT Statewide Mortality Review Policy and Procedures.<br>p. Caregivers Criminal History Screening Requirements, 7.1.9 NMAC.<br>q. Quality Management System and Review Requirements for Providers of Community Based Services, 7.1.13 NMAC.<br>r. All Medicaid Regulations of the Medical Assistance Division of the HS D.<br>s. Health Insurance Portability and Accountability Act (HIPAA).<br>t. DEPARTMENT Sanctions Policy.<br>u. All other regulations, standards, policies and procedures, guidelines and interpretive memoranda of the DDSD and the DHI of the DEPARTMENT.<br><br>**Chapter 18 Incident Management:**<br>**18.1 Training on Abuse, Neglect, and Exploitation (ANE) Recognition and Reporting:** All employees, contractors, and volunteers shall be trained on the in-person ANE training curriculum approved by DOH. Employees or volunteers can work with a DD Waiver participant prior to receiving the training only if directly supervised, at all times, by a trained staff. Provider Agencies are responsible | | | |

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

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

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

| Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans) | Condition of Participation Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019<br>**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.<br>DD Waiver Provider Agencies are required to adhere to the following:<br>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.<br>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.<br>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.<br>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. | After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.<br><br>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 1 of 4 individuals.<br><br>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:<br><br>**Health Care Plans:**<br>***Health Issues Preventing Desired Level of Participation:***<br>• Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.<br><br>**Medical Emergency Response Plans:**<br>***GERD:***<br>◦ Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**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?)*: → | |

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| 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.<br>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.<br>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.<br><br>**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:<br>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:<br>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;<br>b. clinical recommendations made by | | | |

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| registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy;<br>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and<br>d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.<br><br>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:<br>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.<br>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.<br>c. Providers support the person/guardian to make an informed decision.<br>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.<br><br>**Chapter 13 Nursing Services:**<br>**13.2.5 Electronic Nursing Assessment and Planning Process:** The nursing assessment | | | |

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

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| desired by adding ANS hours for assessment and consultation to their budget.<br>4. When completing the e-CHAT, the nurse is required to review and update the electronic record and consider the diagnoses, medications, treatments, and overall status of the person. Discussion with others may be needed to obtain critical information.<br>5. The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections.<br><br>**13.2.7 Aspiration Risk Management Screening Tool (ARST)**<br><br>**13.2.8 Medication Administration Assessment Tool (MAAT):**<br>1. A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting.<br>2. After completion of the MAAT, the nurse will present recommendations regarding the level of assistance with medication delivery (AWMD) to the IDT. A copy of the MAAT will be sent to all the team members two weeks before the annual ISP meeting and the original MAAT will be retained in the Provider Agency records.<br>3. Decisions about medication delivery are made by the IDT to promote a person's maximum independence and community integration. The IDT will reach consensus regarding which criteria the person meets, as indicated by the results of the MAAT and the nursing recommendations, and the decision is documented this in the ISP.<br><br>**13.2.9 Healthcare Plans (HCP):**<br>1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be | | | |

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| 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.<br>2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs plans that the nurse determines are warranted.<br><br>**13.2.10 Medical Emergency Response Plan (MERP):**<br>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.<br>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.<br><br>**Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and** | | | |

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| **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.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015<br>**Chapter 6 (CCS) 2. Service Requirements. E.** The agency nurse(s) for Customized Community Supports providers must provide the following services: 1. Implementation of pertinent PCP orders; ongoing oversight and monitoring of the individual's health status and medically related supports when receiving this service;<br>**3. Agency Requirements: Consumer Records Policy:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. | | | |

| Tag # 1A31.2 Human Right Committee Composition | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018<br>**3.3 Human Rights Committee:** Human Rights Committees (HRC) exist to protect the rights and freedoms of all waiver participants through the review of proposed restrictions to a person's rights based on a documented health and safety concern. HRCs monitor the implementation of certain time- limited restrictive interventions designed to protect a waiver participant and/or the community from harm. An HRC may also serve other functions as appropriate, such as the review of agency policies on sexuality if desired. HRCs are required for all Living Supports (Supported Living, Family Living, Intensive Medical Living Services), Customized Community Supports (CCS) and Community Integrated Employment (CIE) Provider Agencies.<br>1. HRC membership must include:<br>a. at least one member with a diagnosis of I/DD;<br>b. a parent or guardian of a person with I/DD; or<br>c. a member from the community at large that is not associated with DD Waiver services.<br>2. Although not required, members from the health services professions (e.g., a physician or nurse), and those who represent the ethnic and cultural diversity of the community are highly encouraged.<br>3. Committee members must abide by HIPAA.<br>4. All committee members will receive training on human rights, HRC requirements, and other pertinent DD Waiver Service Standards prior to their voting participation on the HRC. A committee member trained by the Bureau of Behavioral Supports (BBS) may conduct training for other HRC members, with prior approval from BBS.<br>5. HRCs will appoint an HRC chair. Each | Based on interview, the Agency did not ensure the correct composition of the human rights committee.<br><br>**When asked if the Agency had an HRC committee, the following was reported:**<br><br>• #502 stated, "We don't have anyone needing HRC. We have a verbal agreement with another agency to join if we need it, nothing in writing." | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**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?)*: → | |

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| committee chair shall be appointed to a two-year term. Each chair may serve only two consecutive two-year terms at a time.<br>6. While agencies may have an intra-agency HRC, meeting the HRC requirement by being a part of an interagency committee is also highly encouraged. | | | |

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
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| ***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; Re-Issue: 12/28/2018; Eff 1/1/2019<br>**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:<br>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.<br>2. Comprehensive documentation of direct service delivery must include, at a minimum:<br>a. the agency name;<br>b. the name of the recipient of the service;<br>c. the location of the service;<br>d. the date of the service;<br>e. the type of service;<br>f. the start and end times of the service;<br>g. the signature and title of each staff member who documents their time; and<br>h. the nature of services.<br>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.<br>4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any of | Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 4 of 4 individuals.<br><br>Individual #1<br>February 2019<br>• The Agency billed 81 units of Customized Community Supports (Group) (T2021 HB U8) from 2/4/2019 through 2/7/2019. Documentation received accounted for 80 units.<br><br>• The Agency billed 23 units of Customized Community Supports (Group) (T2021 HB U8) from 2/25/2019 through 2/28/2019. Documentation received accounted for 22 units.<br><br>March 2019<br>• The Agency billed 29 units of Customized Community Supports (Group) (T2021 HB U8) from 3/4/2019 through 3/7/2019. Documentation received accounted for 28 units.<br><br>• The Agency billed 27 units of Customized Community Supports (Group) (T2021 HB U8) from 3/18/2019 through 3/21/2019. Documentation received accounted for 25 units.<br><br>Individual #2<br>February 2019 | **Provider:**<br>**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?)***:** →<br><br>**Provider:**<br>**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?)***:** → | |

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| the following for a period of at least six years from the payment date:<br>a. treatment or care of any eligible recipient;<br>b. services or goods provided to any eligible recipient;<br>c. amounts paid by MAD on behalf of any eligible recipient; and<br>d. any records required by MAD for the administration of Medicaid.<br><br>**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.<br><br>**21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following:<br>1. A day is considered 24 hours from midnight to midnight.<br>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.<br>3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months.<br>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:<br>a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%).<br>b. The receiving Provider Agency bills the remaining days up to 340 for the ISP year.<br><br>**21.9.2 Requirements for Monthly Units:** For | • The Agency billed 41 units of Customized Community Supports (Group) (T2021 HB U8) from 2/25/2019 through 2/28/2019. Documentation received accounted for 40 units.<br><br>March 2019<br>• The Agency billed 39 units of Customized Community Supports (Group) (T2021 HB U8) from 3/4/2019 through 3/7/2019. Documentation received accounted for 36 units.<br><br>• The Agency billed 24 units of Customized Community Supports (Group) (T2021 HB U8) from 3/25/2019 through 3/26/2019. Documentation received accounted for 23 units.<br><br>Individual #3<br>February 2019<br>• The Agency billed 23 units of Customized Community Supports (Individual) (H2021 HB U1) from 2/4/2019 through 2/6/2019. Documentation received accounted for 22 units.<br><br>• The Agency billed 39 units of Customized Community Supports (Group) (T2021 HB U7) from 2/11/2019 through 2/13/2019. Documentation received accounted for 38 units.<br><br>• The Agency billed 22 units of Customized Community Supports (Group) (T2021 HB U7) from 2/25/2019 through 2/27/2019. Documentation received accounted for 21 units.<br>March 2019<br>• The Agency billed 38 units of Customized | | |

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| services billed in monthly units, a Provider Agency must adhere to the following:<br>1. A month is considered a period of 30 calendar days.<br>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.<br>3. Monthly units can be prorated by a half unit.<br>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.<br><br>**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:<br>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.<br>2. Services that last in their entirety less than eight minutes cannot be billed.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015<br>**CHAPTER 6 (CCS) 4. REIMBURSEMENT**<br>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 | Community Supports (Group) (T2021 HB U7) from 3/11/2019 through 3/13/2019. Documentation received accounted for 36 units.<br><br>• The Agency billed 35 units of Customized Community Supports (Group) (T2021 HB U7) from 3/18/2019 through 3/20/2019. Documentation received accounted for 34 units.<br><br>• The Agency billed 10 units of Customized Community Supports (Individual) (H2021 HB U1) on 3/20/2019. Documentation received accounted for 9 units.<br><br>• The Agency billed 32 units of Customized Community Supports (Group) (T2021 HB U7) from 3/25/2019 through 3/27/2019. Documentation received accounted for 30 units.<br><br>April 2019<br>• The Agency billed 30 units of Customized Community Supports (Group) (T2021 HB U7) from 4/1/2019 through 4/3/2019. Documentation received accounted for 29 units.<br><br>• The Agency billed 23 units of Customized Community Supports (Group) (T2021 HB U7) from 4/8/2019 through 4/9/2019. Documentation received accounted for 22 units.<br><br>• The Agency billed 31 units of Customized Community Supports (Group) (T2021 HB U7) from 4/22/2019 through 4/24/2019. Documentation received accounted for 30 units. | | |

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| required to comply with the New Mexico Human Services Department Billing Regulations.<br><br>B. **Billable Unit:**<br>1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit.<br>2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit.<br>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.<br>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.<br>5. The billable unit for Individual Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit.<br>6. The billable unit for Fiscal Management for Adult Education is one dollar per unit including a 10% administrative processing fee.<br>7. The billable units for Adult Nursing Services are addressed in the Adult Nursing Services Chapter.<br>**C. Billable Activities: All DSP activities that are:**<br>a. Provided face to face with the individual;<br>b. Described in the individual's approved ISP;<br>c. Provided in accordance with the Scope of Services; and<br>d. Activities included in billable services, activities or situations. | Individual #4<br>February 2019<br>• The Agency billed 62 units of Customized Community Supports Group (T2021 HB U8) from 2/26/2019 through 2/28/2019. Documentation received accounted for 61 units. | | |

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date: August 20, 2019

To: Doris A. Roberts, Executive Director
Provider: All Individuals First, Inc.
Address: 2101 Trinity Drive, Suite A-3
City, State, Zip: Los Alamos, New Mexico 87544

E-mail Address: allindividualsfirst@gmail.com

Region: Northeast
Survey Date: May 24 - 29, 2019
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2018:*** Customized Community Supports

Survey Type: Routine

Dear Doris A. Roberts;

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.19.4.DDW.82772835.2.RTN.09.19.232