Date:	January 2, 2020
To:	Sheilla Allen, Executive Director
Provider:	Better Together Home and Community Services, LLC
Address:	405 E. Gladden
City, State, Zip:	Farmington, New Mexico 87401
E-mail Address:	sallen@bettertogetherhcs.com
Region:	Northwest
Routine Survey:	May 17 - 23, 2019
Verification Survey:	December 6 - 11, 2019
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Family Living, Customized In-Home Supports, Customized Community Supports and Community Integrated Employment Services
Survey Type:	Verification
Team Leader:	Yolanda J. Herrera, RN, Nurse Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Member:	Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau

Dear Ms. Sheilla Allen;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on May 17 - 23, 2019*.

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

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

The following tags are identified as Standard Level:

- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency) **(New / Repeat Findings)**
- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements **(New / Repeat Findings)**
- Tag# 1A26 Consolidated On-line Registry Employee Abuse Registry **(New Finding)**

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

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

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

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

1. **Quality Management Bureau, Attention: Plan of Correction Coordinator**
   5301 Central Ave. NE Suite 400, New Mexico 87108
   MonicaE.Valdez@state.nm.us

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

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

Please call the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 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,

Yolanda J. Herrera, RN

Yolanda J. Herrera, RN
Nurse Healthcare Surveyor / Team Lead
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	December 6, 2019
Contact:	**Better Together Home and Community Services, LLC** Beth Sandusky, LPN, Quality Assurance / Director **DOH/DHI/QMB** Yolanda J. Herrera, RN Team Lead/Nurse Healthcare Surveyor
Desk Audit Entrance Conference Date:	December 9, 2019
Present:	**Better Together Home and Community Services, LLC** Beth Sandusky, LPN, Quality Assurance / Director Brianna Lopez, Service Coordinator **DOH/DHI/QMB** Yolanda J. Herrera, RN Team Lead/Nurse Healthcare Surveyor
Exit Conference Date:	December 11, 2019
Present:	**Better Together Home and Community Services, LLC** Beth Sandusky, LPN, Quality Assurance / Director **DOH/DHI/QMB** Yolanda J. Herrera, RN Team Lead/Nurse Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator **DDSD - Northwest Regional Office** Cathy Saxton, Northwest Region Case Manager Coordinator
Administrative Locations Visited	1
Total Sample Size	12 0 - *Jackson* Class Members 12 - Non-*Jackson* Class Members 7 - Family Living 1 - Customized In-Home Supports 5 - Customized Community Supports 4 - Community Integrated Employment Services
Persons Served Records Reviewed	12
Direct Support Personnel Interviewed during Routine Survey	11
Direct Support Personnel Records Reviewed	49
Substitute Care/Respite Personnel Records Reviewed	22
Service Coordinator Records Reviewed	1
Administrative Interviews completed during	

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - Medication Administration Records
  - Medical Emergency Response Plans
  - Therapy Evaluations and Plans
  - Healthcare Documentation Regarding Appointments and Required Follow-Up
  - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
NM Attorney General's Office
IRC – Internal Review Committee

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 Coordination - Nurse Availability / Knowledge
- **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:
- The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Bureau Chief **within 10 business days** of receipt of the final Report of Findings **(*Note: No extensions are granted for the IRF).***
- 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/
- The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
- The IRF request must include all supporting documentation or evidence.
- If you have questions about the IRF process, email the IRF Chairperson, Valerie V. Valdez at valerie.valdez@state.nm.us for assistance.

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

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

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

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

Attachment D

QMB Determinations of Compliance

Compliance:

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

Partial-Compliance with Standard Level Tags:

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

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.

2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

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

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

Non-Compliance:

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

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

2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

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

Agency: **Better Together Home and Community Services, LLC – Northwest Region**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Family Living, Customized In-Home Supports, Customized Community Supports and Community Integrated Employment Services
Survey Type: Verification
Routine Survey: **May 17 - 23, 2019**
Verification Survey: **December 6 - 11, 2019**

Standard of Care	Routine Survey Deficiencies May 17 - 23, 2019	Verification Survey New and Repeat Deficiencies December 6 - 11, 2019
Service Domain: Service Plans: ISP Implementation - *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)	**Standard Level Deficiency**	**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. 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 disability's 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	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 9 of 14 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #2 • According to the Live Outcome; Action Step for "Gather chickens into chicken coop with staff assistance" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2019. • According to the Live Outcome; Action Step for "Work on her list of tasks" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/2019.	**New / Repeat Finding:** Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 12 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #9 • According to the Live Outcome; Action Step for "…will swipe icon on tablet to show completion of chores" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2019. • According to the Live Outcome; Action Step for "… and FLP will practice with the app" is to be completed 2 times per week. Evidence found indicated it was not being completed at the

capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 6: Individual Service Plan (ISP)** **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records** **20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant	Individual #4 • According to the Live Outcome; Action Step for "Research recipes" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2019. • According to the Live Outcome; Action Step for "Prepare dessert with assistance" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/2019. Individual #9 • According to the Live Outcome; Action Step for "…will swipe icon on tablet to show completion of chores" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/2019. **Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #10 • According to the Live Outcome; Action Step for "with assistance...will shop for groceries" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2019 - 4/2019. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #7 • According to the Fun Outcome; Action Step for "...will explore new music on the internet" 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 11/2019. • According to the Live Outcome; Action Step for "…w/ assistance will look up meals he likes and research healthier alternatives of how to prepare" 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 11/2019.

information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 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. 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. 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. 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. 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. 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	required frequency as indicated in the ISP for 2/2019 and 4/2019. • According to the Fun Outcome; Action Step for "...will download songs that she likes" 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2019 and 4/2019. • According to the Fun Outcome; Action Step for "will list her favorite songs in a notebook" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2019 - 4/2019. Individual #8 • According to the Fun Outcome; Action Step for "Create scrapbook" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2019 and 4/2019. • According to the Work/Learn Outcome; Action Step for "Take pictures with tablet" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/2019. Individual #13 • According to the Fun Outcome; Action Step for "Research game ideas" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2019. Individual #14 • According to the Fun Outcome; Action Step for "Plan and invite guests" is to be completed 1 time per month. Evidence found indicated it was not	

from services.	being completed at the required frequency as indicated in the ISP for 4/2019. • According to the Fun Outcome; Action Step for "Show and tell poster" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2019. **Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #5 • According to the Work/Learn Outcome; Action Step for "Download apps" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2019 and 4/2019. • According to the Work/Learn Outcome; Action Step for "Collect work schedule" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2019. • According to the Work/Learn Outcome; Action Step for "Enter schedule and important dates into calendar" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2019 and 3/2019.	

Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	Standard Level Deficiency	Standard Level Deficiency
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible	Based on record review, the Agency did not complete written status reports as required for 13 of 14 individuals receiving Living Care Arrangements and Community Inclusion. **Family Living Semi- Annual Reports:** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 5/1/2018 – 4/30/2020. Semi-Annual Report 11/2018 - 12/30/2018; Date Completed: 1/25/2019; ISP meeting held on 1/29/2019).* • Individual #2 - Report not completed 14 days prior to the Annual ISP meeting. *(2/1/2018 - 1/31/2018. Semi-Annual Report 8/1/2018 - 9/30/2018; Date Completed: 11/26/2018; ISP meeting held on 10/10/2018).* • Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/6/2017 – 9/5/2018. Semi-Annual Report 2/15/2018 - 6/15/2018; Date Completed: 7/2/2018; ISP meeting held on 6/25/2018).* • Individual #4 - None found for 7/2018 - 10/2018. *(Term of ISP 1/12/2019 - 1/22/2020. ISP meeting held on 10/26/2018).* • Individual #9 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/26/2017 – 10/25/2018. Semi-Annual Report 4/2018 - 6/2018; Date Completed: 8/18/2018; ISP meeting held on 7/23/2018).* • Individual #12 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 5/10/2018 - 5/9/2019. Semi-Annual Report 11/10/2018 - 1/10/2019; Date Completed: 2/28/2019; ISP meeting held on 2/5/2019).*	**New / Repeat Finding:** Based on record review, the Agency did not complete written status reports as required for 5 of 12 individuals receiving Living Care Arrangements and Community Inclusion. **Family Living Semi- Annual Reports:** • Individual #4 - None found for 7/2019 - 9/2019. *(Term of ISP 1/12/2019 - 1/11/2020. ISP meeting held on 10/15/2019).* • Individual #9 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/26/2018 – 10/25/2019. Semi-Annual Report 4/26/2019 - 7/10/2019; Date Completed: 8/16/2019; ISP meeting held on 7/24/2019).* **Nursing Semi-Annual:** • Individual #2 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 2/1/2019 – 1/31/2020. Semi-Annual Report 2/1/2019 - 11/10/2019; Date Completed: 11/10/2019; ISP meeting held on 11/10/2019).* • Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/16/2018 - 9/15/2019. Semi-Annual Report 9/16/2018 - 6/5/2019; Date Completed: 6/5/2019; ISP meeting held on 6/11/2019).* • Individual #8 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 11/1/2018 - 10/31/2019. Semi-Annual Report 5/1/2018 - 7/31/2019; Date Completed: 12/11/2019; ISP meeting held on 8/6/2019).*

records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **Chapter 19: Provider Reporting Requirements: 19.5 Semi-Annual Reporting:** The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDSD for QA activities. Semi-annual reports are required as follows: 1. DD Waiver Provider Agencies, except AT, EMSP,	• Individual #13 - None found for 10/2018 - 3/2019. *(Term of ISP 10/1/2018 - 9/30/2019);* Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/1/2017 - 9/30/2018). Semi-Annual Report 4/2018; Date Completed: 5/18/2018; ISP meeting held on 5/29/2018).* • Individual #14 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/1/2017 - 9/30/2018. Semi-Annual Report 4/1/2018 - 4/30/2018; Date Completed: 5/18/2018; ISP meeting held on 5/29/2018).* **Community Integrated Employment Services Semi-Annual Reports:** • Individual #5 - None found for 7/2018 - 2/2019. *(Term of ISP 7/9/2018 - 7/8/2019);* Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 7/9/2017 -7/8/2018. Semi-Annual Report 1/2018 - 3/2018; Date Completed: 4/4/2018; ISP meeting held on 4/4/2018).* • Individual #11 - None found for 10/2018 - 4/2019. *(Term of ISP 10/15/2018 - 10/14/2019.);* Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/15/2017 – 10/14/2018. Semi-Annual Report 10/15/2017 - 10/14/2018; Date Completed: 2/13/2019; ISP meeting held on 7/25/2018).* • Individual #12 - Report not completed 14 days prior to the Annual ISP meeting. (*Semi-Annual Report 11/10/2018 - 1/10/2019; Date Completed: 2/1/2019; ISP meeting held on 2/5/2019).* **Customized Community Supports Semi-Annual Reports:** • Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/6/2017 - 9/15/2019. Semi-Annual Report 2/15/2018 -*	

Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports. 2. A Respite Provider Agency must submit a semi-annual progress report to the CM that describes progress on the Action Plan(s) and Desired Outcome(s) when Respite is the only service included in the ISP other than Case Management for an adult age 21 or older. 3. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days). 4. The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting. 5. Semi-annual reports must contain at a minimum written documentation of: a. the name of the person and date on each page; b. the timeframe that the report covers; c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering; d. a description of progress towards Desired Outcomes in the ISP related to the service provided; e. a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing); f. significant changes in routine or staffing if applicable; g. unusual or significant life events, including significant change of health or behavioral health condition; h. the signature of the agency staff responsible for preparing the report; and i. any other required elements by service type that are detailed in these standards.	*6/15/2018; Date Completed: 7/3/2018; ISP meeting held on 6/25/2018).* • Individual #7 - None found for 4/2018 - 6/2018. *(Term of ISP 10/1/2018 - 9/30/2019. ISP meeting held on 6/26/2018).* • Individual #8 - Report not completed 14 days prior to the Annual ISP meeting. *(11/1/2017 - 10/31/2018. Semi-Annual Report 5/2018 - 10/2018; Date Completed: 2/2/2019; ISP meeting held on 7/24/2018).* • Individual #12 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 5/10/2017 – 5/9/2018. Semi-Annual Report 11/2018 - 1/9/2019; Date Completed: 2/2/2019; ISP meeting held on 2/5/2019).* • Individual #13 – None found for 10/2018 - 3/2019. *(Term of ISP 10/1/2018 - 9/30/2019.);* Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/1/2017 - 9/30/2019. Semi-Annual Report 4/2018 - 9/2018; Date Completed: 3/11/2019; ISP meeting held on 5/29/2018).* • Individual #14 - None found for 10/2018 - 3/2019. *(Term of ISP 10/1/2018 - 9/30/2019.*); Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/2017- 9/30/2018. Semi-Annual Report 4/1/2018 - 9/30/2018; Date Completed: 3/11/2019; ISP meeting held on 5/18/2018).* **Nursing Semi-Annual / Quarterly Reports:** • Individual #2 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 2/1/2018 – 1/31/2019. Semi-Annual Report 2/1/2018 - 1/31/2019; Date Completed: 5/20/2019; ISP meeting held on 10/10/2018).*	

	• Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/16/2017 - 9/15/2018. Semi-Annual Report 4/2018 - 6/2018; Date Completed: 5/14/2019; ISP meeting held on 6/25/2018).* • Individual #7 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/1/2017 - 9/30/2018. Semi-Annual Report 4/2018 - 6/2018; Date Completed: 5/22/2019; ISP meeting held on 6/26/2018).* • Individual #8 - None found for 11/2018 - 4/2019 and 5/2018 - 6/2018. *(Term of ISP 11/1/2018 - 10/31/2019. ISP meeting held on 7/24/2018).* • Individual #12 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 5/10/2018 – 5/9/2019. Semi-Annual Report 11/10/2018 - 5/9/2019; Date Completed: 5/20/2019; ISP meeting held on 2/5/2019).* • Individual #13 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/1/2017 - 9/30/2018. Semi-Annual Report 8/2017 - 5/2018; Date Completed: 5/20/2019; ISP meeting held on 5/29/2018).* • Individual #14 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/1/2018 – 9/30/2019. Semi-Annual Report 8/1/2017 - 5/24/2018; Date Completed: 5/24/2018; ISP meeting held on 5/29/2018).*	

Standard of Care	Routine Survey Deficiencies May 17 - 23, 2019	Verification Survey New and Repeat Deficiencies December 6 - 11, 2019
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 # 1A26 Consolidated On-line Registry Employee Abuse Registry	**Standard Level Deficiency**	**Standard Level Deficiency**
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address,	**NA**	**New Finding:** Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 72 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Personnel (DSP):** • #580 – Date of hire 10/1/2019, completed 12/9/2019.

date of birth, social security number, and other appropriate identifying information required by the registry. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.		

Standard of Care	Routine Survey Deficiencies May 17 - 23, 2019	Verification Survey New and Repeat Deficiencies December 6 - 11, 2019
Service Domain: Service Plans: ISP Implementation - *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # IS04 Community Life Engagement	**Standard Level Deficiency**	**COMPLETE**
Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare requirements)	**Condition of Participation Level Deficiency**	**COMPLETE**
Service Domain: Qualified Providers - *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A22 Agency Personnel Competency	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A25.1 Caregiver Criminal History Screening	**Condition of Participation Level Deficiency**	**COMPLETE**
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A03 Continuous Quality Improvement System & KPIs	**Standard Level Deficiency**	**COMPLETE**

	Verification Survey Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date: January 23, 2020

To: Sheilla Allen, Executive Director
Provider: Better Together Home and Community Services, LLC
Address: 405 E. Gladden
City, State, Zip: Farmington, New Mexico 87401

E-mail Address: sallen@bettertogetherhcs.com

Region: Northwest
Routine Survey: May 17 - 23, 2019
Verification Survey: December 6 - 11, 2019

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2018:*** Family Living, Customized In-Home Supports, Customized Community Supports and Community Integrated Employment Services

Survey Type: Verification

Dear Ms. Sheilla Allen;

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,

Monica Valdez, BS

Monica Valdez, BS
Healthcare Surveyor Advanced/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.20.2.DDW.13631071.1.VER.09.20.023