Date:	November 8, 2019
To:	Angelee James, Interim Director
Provider:	Coyote Canyon Rehabilitation Center, Inc.
Address:	10 Miles East Navajo Route 9
State/Zip:	Brimhall, New Mexico 87310
E-mail Address:	ajames@ccrcnm.org vleslie@ccrcnm.org ysandoval@ccrcnm.org skee@ccrcnm.org mjarvison@ccrcnm.org lucille.mccabe@ccrcnm.org jonathan.avery@ccrcnm.org jjansen@ccrcnm.org
Region:	Northwest
Survey Date:	October 4 – 10, 2019
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Customized In-Home Supports, Customized Community Supports, Community Integrated Employment Services
Survey Type:	Routine
Team Leader:	Kayla R. Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Yolanda J. Herrera, RN, Nurse Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Heather Driscoll, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. James;

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:

Non-Compliance: This determination is based on noncompliance with 17 or more total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level tag or any amount of Standard Level Tags with 6 or more 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:

1. Tag # 1A32 Administrative Case File: Individual Service Plan Implementation
2. Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
3. Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
4. Tag # 1A09 Medication Delivery Routine Medication Administration
5. Tag # 1A09.1 Medication Delivery PRN Medication Administration
6. Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication
7. Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File (Other Required Documents)
- Tag # 1A08.1 Administrative and Residential Case File: Progress Notes
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(*Not Completed at Frequency)
- Tag # 5I02 Community Inclusion: Scope of Services: CSS Observation
- Tag # IS04 Community Life Engagement
- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements
- Tag # 1A20 Direct Support Personnel Training
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A43.1 General Events Reporting: Individual Reporting
- Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)
- Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider
- Tag # 1A33.1 Board of Pharmacy – License
- Tag #LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)
- Tag # IS30 Customized Community Supports Reimbursement
- Tag # LS26 Supported Living Reimbursement

Plan of Correction:

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

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

Corrective Action for Current Citation:

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

On-going Quality Assurance/Quality Improvement Processes:

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

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

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

1. **Quality Management Bureau, Attention: Monica Valdez, Plan of Correction Coordinator 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108**

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:

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

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, 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,

Kayla R. Benally, BSW

Kayla R. Benally, BSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	October 4, 2019
Contact:	**Coyote Canyon Rehabilitation Center Inc.** Clarissa Yazzie, Administration **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead / Healthcare Surveyor
On-site Entrance Conference Date:	October 7, 2019
Present:	**Coyote Canyon Rehabilitation Center Inc.** Angelee James, Interim Executive Director Yvette Sandoval, QA & Compliance Officer Sherry Kee, Case Manager Jonathan Avery, Employment Service Manager Lucille McCabe, Day Hab Manager Margie Jarvison, Community Living Manager Jason Jansen, Health Department Manager **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead / Healthcare Surveyor Lora Norby, Healthcare Surveyor Yolanda J. Herrera, RN, Nurse Healthcare Surveyor Heather Driscoll, AA, Healthcare Surveyor
Exit Conference Date:	October 10, 2019
Present:	**Coyote Canyon Rehabilitation Center Inc.** Angelee James, Interim Executive Director Sherry Kee, Case Manager Laura James, Case Manager Valerie Leslie, RN Jonathan Avery, Employment Service Manager Lucille McCabe, Day Hab Manager Margie Jarvison, Community Living Manager Jason Jansen, Health Department Manager Amerind Avery, Community Living Assistant Manager Mary Plummer, Finance Manager Eunice Hill, Vending Instructor Kyle Henry, CCS Instructor Shonna Toadlena, CCS Instructor Jennifer Dixon, Community Living Instructor Gilbert Wilson, Art Instructor Alicia Largo, Health Technician Anthony Howard, Job Developer William Howard, Staff Development Trainer Gabriel Jim, Billing Technician Lenora Gray, Therap Coordinator Amanda Dennison, Office Assistant **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead / Healthcare Surveyor Lora Norby, Healthcare Surveyor Yolanda J. Herrera, RN, Nurse Healthcare Surveyor Heather Driscoll, AA, Healthcare Surveyor

DDSD - NW Regional Office
Crystal Wright, Regional Director
Dennis O' Keefe, Generalist
Orlinda Charleston, Community Inclusion Coordinator

Administrative Locations Visited:	1
Total Sample Size:	8
	0 - *Jackson* Class Members 8 - Non-*Jackson* Class Members
	7 - Supported Living 1 - Customized In-Home Supports 8 - Customized Community Supports 4 - Community Integrated Employment
Total Homes Visited	4
❖ Supported Living Homes Visited	4 *Note: The following Individuals share a SL residence:* 1. #2, 4, 5 2. #3, 8
Persons Served Records Reviewed	8
Persons Served Interviewed	3
Persons Served Observed	4 (Four Individuals chose not to participate in the interview process)
Persons Served Not Seen and/or Not Available	1
Direct Support Personnel Records Reviewed	54
Direct Support Personnel Interviewed	14
Service Coordinator Records Reviewed	1
Nurse Interview	1

Administrative Processes and Records Reviewed:

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

- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

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

Attachment A

Provider Instructions for Completing the QMB Plan of Correction (POC) Process

Introduction:
After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued deficiencies and non-compliance.

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the DDSD Regional Office for purposes of contract management or the Internal Review Committee [IRC] for possible actions or sanctions).

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 505-273-1930 or email at MonicaE.Valdez@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, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@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 Monica Valdez, POC Coordinator in any of the following ways:
    a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108
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%:

1. **1A08.3 –** Administrative Case File: Individual Service Plan / ISP Components
2. **1A32 –** Administrative Case File: Individual Service Plan Implementation
3. **LS14 –** Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
4. **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%:

20 **1A20 -** Direct Support Personnel Training
21 **1A22 -** Agency Personnel Competency
22 **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)

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 **(*Note: No extensions are granted for the IRF)*.**
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, 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:

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

26 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 total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level 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: **Coyote Canyon Rehabilitation Center, Inc. – Northwest Region**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Supported Living, Customized In-Home Supports, Customized Community Supports, Community Integrated Employment Services
Survey Type: Routine
Survey Date: **October 4 – 10, 2019**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08 Administrative Case File (Other Required Documents)	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: • 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. • 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. • Provider Agencies are responsible for	Based on record review the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 8 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **IDT Meeting Minutes:** • Not Found (#3)	**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?)*: →	

ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. • 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. • 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. • 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. • All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. ***20.5.1 Individual Data Form (IDF):*** The Individual Data Form provides an overview of demographic information as well as other key personal, programmatic, insurance, and health related information. It lists medical information; assistive technology or adaptive equipment; diagnoses; allergies; information about whether a guardian or advance directives are in place; information about behavioral and health related needs; contacts of Provider Agencies and team members and other critical information. The IDF automatically loads information into other fields and forms and must be complete and kept current. This form is initiated by the CM. It must			

be opened and continuously updated by Living Supports, CCS- Group, ANS, CIHS and case management when applicable to the person in order for accurate data to auto populate other documents like the Health Passport and Physician Consultation Form. Although the Primary Provider Agency is ultimately responsible for keeping this form current, each provider collaborates and communicates critical information to update this form. **Chapter 3: Safeguards *3.1.2 Team Justification Process***: DD Waiver participants may receive evaluations or reviews conducted by a variety of professionals or clinicians. These evaluations or reviews typically include recommendations or suggestions for the person/guardian or the team to consider. The team justification process includes: 1. Discussion and decisions about non-health related recommendations are documented on the Team Justification form. 2. The Team Justification form documents that the person/guardian or team has considered the recommendations and has decided: 1. to implement the recommendation; 2. to create an action plan and revise the ISP, if necessary; or 3. not to implement the recommendation currently. All DD Waiver Provider Agencies participate in information gathering, IDT meeting attendance, and accessing supplemental resources if needed and desired. The CM ensures that the Team Justification Process is followed and complete.			

Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: 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. 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. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 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. Each Provider Agency is responsible for maintaining the daily or other contact notes	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 3 of 8 Individuals. Review of the Agency individual case files revealed the following items were not found: **Administrative Case File:** **Supported Living Progress Notes/Daily Contact Logs:** • Individual #3 - None found for 6/9, 8/1 – 3 & 8 - 21, 2019 • Individual #7 – None found for 7/7/2019 • Individual #8 – None found for 6/1 – 30 & 8/1 - 7, 2019	**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?)*: →	

documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 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. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.			
Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	**Condition of Participation 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 disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. 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 8 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #3 • None found regarding: Live Outcome/Action Step: "…will gather her dirty clothes and sort them then load her clothes into the washer with staff assistance" for 6/2019 - 8/2019. Action step is to be completed 2 times per month. • None found regarding: Live Outcome/Action Step: "…will add laundry soup into the washer and start the washer with staff assistance" for 6/2019 - 8/2019. Action step is to be completed 2 times per month. • None found regarding: Live Outcome/Action Step: "…will transfer her laundry to the dryer and start the dryer with staff assistance" for 6/2019 - 8/2019. Action step is to be completed 2 times per month. Individual #8 • None found regarding: Live Outcome/Action Step: "With staff assistance … will choose a	**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?)*: →	

developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 6: Individual Service Plan (ISP) 6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:	recipe to prepare" for 6/2019 & 8/2019. Action step is to be completed 1 time per month. • None found regarding: Live Outcome/Action Step: "With staff assistance …will gather ingredients" for 6/2019 & 8/2019. Action step is to be completed 1 time per month. • None found regarding: Live Outcome/Action Step: "With staff assistance … will prepare the baked goods" for 6/2019 & 8/2019. Action step is to be completed 1 time per month. • None found regarding: Live Outcome/Action Step: "…will share the baked goods with her housemates" for 6/2019 & 8/2019. Action step is to be completed 1 time per month. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #2 • No Outcomes or DDSD exemption/decision justification found for Customized Community Supports, Individual (H2021 HB U1) Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver."		

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. 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. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 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. 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. 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. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.			
Tag # 1A32.1 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	Based on administrative record review the Agency did not implement the ISP according to	**Provider:**	

be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include 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]	the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 7 of 8 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #2 • According to the Live Outcome; Action Step for “With hand over hand assistance … will hang and organize his shirts in the closet” 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 6/2019. • According to the Live Outcome; Action Step for “Choose a snack” 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 8/2019. • According to the Live Outcome; Action Step for “Independently pack snacks in lunchbox” 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 8/2019. Individual #4 • According to the Live Outcome; Action Step for “…will select chores and put them on the monthly calendar with assistance” is to be completed 1 time per month. Evidence found indicated it was not being completed at the	**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?)*: →	

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 6: Individual Service Plan (ISP)** **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 8. Client records must contain all documents essential to the service being provided and	required frequency as indicated in the ISP for 6/2019 – 8/2019. • According to the Live Outcome; Action Step for "…will independently complete household chores" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2019 – 8/2019. • According to the Fun Outcome; Action Step for "…will research local walking events with staff assistance" 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 6/2019 – 7/2019. • According to the Fun Outcome; Action Step for "…will participate in a local walking event" 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 7/2019 – 8/2019. Individual #5 • According to the Fun Outcome; Action Step for "With assistance … will work on a birdhouse" 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 7/2019 – 8/2019. Individual #6 • According to the Live Outcome; Action Step for "…will research and choose a traditional meal to prepare" 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 6/2019 – 8/2019.		

essential to ensuring the health and safety of the person during the provision of the service. 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. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 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. 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. 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. 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.	• According to the Live Outcome; Action Step for "…will prepare the chosen meal with staff assistance" 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 6/2019. • According to the Live Outcome; Action Step for "…will share the meal with his housemates" 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 6/2019 – 8/2019. Individual #8 • According to the Live Outcome; Action Step for "With staff assistance … will choose a recipe to prepare" 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 7/2019. • According to the Live Outcome; Action Step for "With staff assistance … will gather ingredients" 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 7/2019. • According to the Live Outcome; Action Step for … will share the baked goods with her housemates" 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 7/2019. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #2		

	• According to the Work/Learn Outcome; Action Step for "Research places to volunteer" 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 7/2019 - 8/2019. • According to the Fun Outcome; Action Step for "Research meaningful activities" 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 7/2019 - 8/2019. • According to the Fun Outcome; Action Step for "Participate in activity and take photos" 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 7/2019. Individual #3 • According to the Fun Outcome; Action Step for "…will gather material needed to work on her blanket with staff 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 6/2019 - 8/2019. • According to the Fun Outcome; Action Step for "…will work on her blanket and add pictures to it with staff 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 6/2019 - 8/2019. Individual #4 • According to the Work Outcome; Action Step for "…will research local place to volunteer		

	with staff 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 6/2019 - 8/2019. • According to the Fun Outcome; Action Step for "With staff assistance … will practice his horseshoes" 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 8/2019. Individual #7 • According to the Fun Outcome; Action Step for …will research activities/events to do with her brother" 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 6/2019-7/2019.		
Tag # 5I02 Community Inclusion: Scope of Services: *CSS Observation*	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 4: Person-Centered Planning (PCP)** **4.1 Essential Elements of Person-Centered Planning (PCP):** Person-centered planning is a process that places a person at the center of planning his/her life and supports. It is an	Based on observation, the Agency did not provide Inclusion services in accordance with each individual's ISP, needs and preferences for 5 of 8 Individuals **During an observation of activities during CCS, the following was found:**	**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?)*: →	

ongoing process that is the foundation for all aspects of the DD Waiver Program and DD Waiver Provider Agencies' work with people with I/DD. The process is designed to identify the strengths, capacities, preferences, and needs of the person. The process may include other people chosen by the person, who are able to serve as important contributors to the process. Overall, PCP involves person-centered thinking, person-centered service planning, and person-centered practice. PCP enables and assists the person to identify and access a personalized mix of paid and non-paid services and supports to assist him or her to achieve personally defined outcomes in the community. The CMS requires use of PCP in the development of the ISP. **4.2 Person-Centered Thinking:** Person-centered thinking involves values, tools and skills to set the foundation for ISP development. Person-centered thinking respects and supports the person with I/DD to: 1. have informed choices; 2. exercise the same basic civil and human rights as other citizens; 3. have personal control over the life he/she prefers in the community of choice; 4. be valued for contributions to his/her community; and 5. be supported through a network of resources, both natural and paid. Person-centered thinking must be employed by all DD Waiver Provider Agencies involved in PCP and the development and/or modification of a person's ISP. Person-centered thinking involves the use of discovery tools and techniques. **Chapter 11: Community Inclusion: 11.3 Implementation of a Meaningful Day:** The	During observation of the Individuals on 10/9/2019 9:05 am. Surveyors observed the Individuals did not have a secure place for the person to store personal belongings. Surveyors observed belongings being stored on chairs, metal cabinets where puzzles and games were being accesses by multiple individuals. (Individual #2, 3, 4, 5, 8) *Per DDW Chapter 11; 11.5 Settings Requirements for Non-Residential Settings: …Provider responsibilities in agency-occupied settings include but are not limited to: 6. Providing a secure place for the person to store personal belongings.*	**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?)*: →	

objective of implementing a Meaningful Day is to plan and provide supports to implement the person's definition of his/her own meaningful day, contained in the ISP. Implementation activities of the person's meaningful day are documented in daily schedules and progress notes. 1. Meaningful Day includes: 1. purposeful and meaningful work; 2. substantial and sustained opportunity for optimal health; 3. self-empowerment; 4. personalized relationships; 5. skill development and/or maintenance; and 6. social, educational, and community inclusion activities that are directly linked to the vision, Desired Outcomes and Action Plans stated in the person's ISP. Community Life Engagement (CLE) is also sometimes used to refer to "Meaningful Day" or "Adult Habilitation" activities. CLE refers to supporting people in their communities, in non-work activities. Examples of CLE activities may include participating in clubs, classes, or recreational activities in the community; learning new skills to become more independent; volunteering; or retirement activities. Meaningful Day activities should be developed with the four guideposts of CLE in mind[1]. The four guideposts of CLE are: 1. individualized supports for each person; 2. promotion of community membership and contribution; 3. use of human and social capital to decrease dependence on paid supports; and 4. provision of supports that are outcome-oriented and regularly monitored. The term "day" does not mean activities between 9:00 a.m. to 5:00 p.m. on weekdays.			

Community Inclusion is not limited to specific hours or days of the week. These services may not be used to supplant the responsibility of the Living Supports Provider Agency for a person who receives both services. **11.5** Settings Requirements for Non-Residential Settings: All individuals have the right to choose where they receive services. All Provider Agencies must facilitate individual choice and must ensure that any service provided in an agency-operated facility is a setting chosen by the person and is integrated in, and supports full access to, the community. Provider responsibilities in agency-occupied settings include but are not limited to: 1. Encouraging and allowing visitors or others from the greater community (aside from paid staff) to be present and visit at times that are convenient for the individuals. It is the responsibility of the Provider Agency to ensure visitors are informed of their responsibilities under HIPAA. 2. Allowing people to access the building to the fullest extent possible while remaining safe. For example, gates, Velcro strips, locked doors, fences or other barriers preventing individuals' entrance to or exit from certain areas should not be used. 3. Ensure the building meets ADA standards and is physically accessible. 4. Ensure that personal support assistance is provided in private settings to the fullest extent possible, including dining options if applicable. 5. Ensuring any staff of the DD Waiver Provider Agency do not talk about an individual(s) in the presence of others or in the presence of the individual as if s/he were not present, and that staff address the			

person directly when discussing the participant or matters concerning the participant. 6. Providing a secure place for the person to store personal belongings. 7. Ensuring people have full access to a dining area with comfortable seating and opportunity to converse with others during break or meal times. 8. Affording dignity to the diners, e.g., people are treated age-appropriately and not required to wear bibs. 9. Assisting with arranging for alternative meals and/or private dining if requested. **11.6 Customized Community Supports (CCS):** CCS for adults are designed to assist a person to increase his/her independence and potentially reduce the amount of paid supports, to establish or strengthen interpersonal relationships, to join social networks, and to participate in typical community life. CCS are based upon the preferences and choices of each person and designed to measure progress toward Desired Outcomes specified in the ISP. Activities include adaptive skill development, adult educational supports, citizenship skills, communication, social skills, self-advocacy, informed choice, community integration, and relationship building.			
Tag # IS04 Community Life Engagement	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 11: Community Inclusion** **11.1 General Scope and Intent of Services:** Community Inclusion (CI) is the umbrella term used to describe services in this chapter. In general, CI refers to opportunities for people	Based on record review, the Agency did not have evidence of their implementation of a meaningful day in daily schedules / individual calendar and progress notes for 8 of 8 Individuals. Review of the individual case files found there is no individualized schedule that can be modified	**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?)*: →	

with I/DD to access and participate in activities and functions of community life. The DD waiver program offers Customized Community Supports (CCS), which refers to non-work activities and Community Integrated Employment (CIE) which refers to paid work experiences or activities to obtain paid work. CCS and CIE services are mandated to be provided in the community to the fullest extent possible. **11.3 Implementation of a Meaningful Day:** The objective of implementing a Meaningful Day is to plan and provide supports to implement the person's definition of his/her own meaningful day, contained in the ISP. Implementation activities of the person's meaningful day are documented in daily schedules and progress notes. 1. Meaningful Day includes: 1. purposeful and meaningful work; 2. substantial and sustained opportunity for optimal health; 3. self-empowerment; 4. personalized relationships; 5. skill development and/or maintenance; and 6. social, educational, and community inclusion activities that are directly linked to the vision, Desired Outcomes and Action Plans stated in the person's ISP. Community Life Engagement (CLE) is also sometimes used to refer to "Meaningful Day" or "Adult Habilitation" activities. CLE refers to supporting people in their communities, in non-work activities. Examples of CLE activities may include participating in clubs, classes, or recreational activities in the community; learning new skills to become more independent; volunteering; or retirement activities. Meaningful	easily based on the individual needs, preferences and circumstances and that outline planned activities per day, week and month including date, time, location and cost of the activity: **Calendar / Daily Calendar**: • Not found (#2, 4, 5, 8) • Not Individualized (#1, 3, 6, 7)	**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?)*: →	

Day activities should be developed with the four guideposts of CLE in mind[1]. The four guideposts of CLE are: 1. individualized supports for each person; 2. promotion of community membership and contribution; 3. use of human and social capital to decrease dependence on paid supports; and 4. provision of supports that are outcome-oriented and regularly monitored. 3. The term "day" does not mean activities between 9:00 a.m. to 5:00 p.m. on weekdays. 4. Community Inclusion is not limited to specific hours or days of the week. These services may not be used to supplant the responsibility of the Living Supports Provider Agency for a person who receives both services.			
Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	**Standard Level Deficiency**		
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall	Based on record review, the Agency did not complete written status reports as required for 8 of 8 individuals receiving Living Care Arrangements and Community Inclusion. **Supported Living Semi-Annual Reports:** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 5/20/2018 – 5/19/2019; Semi-Annual Report*	**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?)*: →	

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; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: 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. 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. Provider Agencies are responsible for ensuring	*11/20/2018 - 5/19/2019; Date Completed: 1/22/2019; ISP meeting held on 1/23/2019).* • Individual #5 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/2/2018 – 9/1/2019; Semi-Annual Report 3/2/2019 – 9/1/2019; Date Completed: 4/30/2019; ISP meeting held on 5/8/2019).* • Individual #8 - None found for 3/2019 - 4/2019. *(Term of ISP 9/2/2018 – 9/1/2019. ISP meeting held on 5/8/2019).* **Customized Community Supports Semi-Annual Reports** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 5/20/2018 – 5/19/2019; Semi-Annual Report 11/20/2018 – 5/19/2019; Date Completed: 1/16/2019; ISP meeting held on 1/23/2019).* • Individual #5 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/2/2018 – 9/1/2019; Semi-Annual Report 3/2/2019 – 9/1/2019; Date Completed: 5/1/2019; ISP meeting held on 5/8/2019).* • Individual #7 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 8/1/2018 – 7/31/2019; Semi-Annual Report 2/1/2019 - 7/31/2019; Date Completed: 3/29/2019; ISP meeting held on 4/3/2019).* **Community Integrated Employment Services Semi-Annual Reports** • Individual #5 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/26/2018 – 9/25/2019. Semi-Annual Report 3/2019 – 9/2019; Date Completed: 6/1/2019; ISP meeting held on 6/4/2019)*	**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?)*: →	

that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 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. 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. 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. 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: • DD Waiver Provider Agencies, except AT, EMSP, Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports.	• Individual #7 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 8/1/2018 – 7/31/2019; Semi-Annual Report 2/1/2019 - 7/31/2019; Date Completed: 3/29/2019; ISP meeting held on 4/3/2019).* **Nursing Semi-Annual / Quarterly Reports:** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 5/20/2018 – 5/19/2019; Semi-Annual Report 11/20/2018 – 5/19/2019; Date Completed: 9/27/2019; ISP meeting held on 1/23/2019).* • Individual #2 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 7/19/2018 – 7/18/2019; Semi-Annual Report 1/19/2019 – 7/15/2019; Date Completed: 7/15/2019; ISP meeting held on 3/27/2019).* • Individual #3 - None found for 3/2019 - 4/2019. *(Term of ISP 9/2018 – 9/2019. ISP meeting held on 5/8/2019).* • Individual #4 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/18/2018 – 9/17/2019; Semi-Annual Report 3/18/2019 – 9/17/2019; Date Completed: 10/2/2019; ISP meeting held on 5/15/2019).* • Individual #5 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/2/2018 – 9/1/2019; Semi-Annual Report 3/2/2019 – 9/1/2019; Date Completed: 10/1/2019; ISP meeting held on 5/8/2019).* • Individual #6 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/26/2018 – 9/25/2019; Semi-Annual Report 3/2019 – 9/2019; Date Completed: 6/4/2019; ISP meeting held on 6/4/2019).*		

• 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. • 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). • 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. • Semi-annual reports must contain at a minimum written documentation of: • the name of the person and date on each page; • the timeframe that the report covers; • timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering; • a description of progress towards Desired Outcomes in the ISP related to the service provided; • a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing); • significant changes in routine or staffing if applicable; • unusual or significant life events, including significant change of health or behavioral health condition; • the signature of the agency staff responsible for preparing the report; and • any other required elements by service type that are detailed in these standards.	• Individual #7 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 8/1/2018 – 7/31/2019; Semi-Annual Report 2/1/2019 – 3/29/2019; Date Completed: 3/29/2019; ISP meeting held on 4/3/2019).* • Individual #8 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/2/2018 – 9/1/2019; Semi-Annual Report 3/2/2019 – 9/1/2019; Date Completed: 10/1/2019; ISP meeting held on 5/8/2019).*		

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	**Condition of Participation Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 2 of 8 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **Annual ISP:** • Not Current (#4, 5)	**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**	

DD Waiver Provider Agencies are required to adhere to the following: 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. 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. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 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. 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. 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. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the	**ISP Teaching and Support Strategies:** ***Individual #4:*** *TSS not found for the following (Live) Outcome Statement / Action Steps:* • "…will gather his clean clothes." • "…will independently fold and organize his clothes." ***Individual #5:*** *TSS not found for the following (Live) Outcome Statement / Action Steps:* • "Sort clothes, load into washer, add detergent." • "Transfer clothes to dryer."	**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?)*: →	

Health Passport and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. Requirements for the *Health Passport* and *Physician Consultation* form are: 2. The Primary and Secondary Provider Agencies must ensure that a current copy of the *Health Passport* and *Physician Consultation* forms are printed and available at all service delivery sites. Both forms must be reprinted and placed at all service delivery sites each time the e-CHAT is updated for any reason and whenever there is a change to contact information contained in the IDF. **Chapter 13: Nursing Services: 13.2.9 Healthcare Plans (HCP)*:*** At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. In collaboration with the IDT, the agency nurse is required to create HCPs that			

address all the areas identified as required in the most current e-CHAT summary **13.2.10 *Medical Emergency Response Plan (MERP):*** **1.** The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP. **2.** MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.			
Standard of Care	**Deficiencies**	**Agency Plan of Correction, On-going QA/QI and Responsible Party**	**Date Due**
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A20 Direct Support Personnel Training	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 17: Training Requirements:** The purpose of this chapter is to outline requirements for completing, reporting and documenting DDSD training requirements for DD Waiver Provider Agencies as well as requirements for certified trainers or mentors of DDSD Core curriculum training. **17.1 Training Requirements for Direct Support Personnel and Direct Support Supervisors:** Direct Support Personnel (DSP)	Based on record review, the Agency did not ensure Orientation and Training requirements were met for 2 of 54 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: **Assisting with Medication Delivery:** • Expired (#533, 542)	**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:**	

and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports. 1. DSP/DSS must successfully: 1. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in 17.10 Individual-Specific Training below. 2. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14 3. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements 4. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. 5. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). 6. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using EPR. Agency DSP and DSS shall maintain certification in a DDSD-approved system if any person they support has a BCIP that includes the use of EPR. 7. Complete and maintain certification in a DDSD-approved medication course if required to assist with medication delivery. 8. Complete training regarding the HIPAA. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD		**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?)*: →	

required core trainings and be on shift with a DSP who has completed the relevant IST. **17.1.2 Training Requirements for Service Coordinators (SC):** Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports. 1. A SC must successfully: 1. Complete IST requirements in accordance with the specifications described in the ISP of each person supported, and as outlined in the 17.10 Individual-Specific Training below. 2. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14. 3. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. 4. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. 5. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). 6. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using emergency physical restraint. Agency SC shall maintain certification in a DDSD-approved system if a person they support has a Behavioral Crisis Intervention Plan that includes the use of emergency physical restraint.			

7. Complete and maintain certification in AWMD if required to assist with medications. 8. Complete training regarding the HIPAA. 2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings.			
Tag # 1A22 Agency Personnel Competency	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 13: Nursing Services *13.2.11 Training and Implementation of Plans:*** RNs and LPNs are required to provide Individual Specific Training (IST) regarding HCPs and MERPs. The agency nurse is required to deliver and document training for DSP/DSS regarding the healthcare interventions/strategies and MERPs that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee as described in Chapter 17.10 Individual-Specific Training. **Chapter 17: Training Requirement** **17.10 Individual-Specific Training:** The following are elements of IST: defined standards of performance, curriculum tailored to teach	Based on interview, the Agency did not ensure training competencies were met for 2 of 14 Direct Support Personnel. **When DSP were asked, if they knew what the Individual's health condition/ diagnosis or when the information could be found, the following was reported:** • DSP #502 stated, "Left side paralysis." Per eCHAT the Individual has a diagnosis of Intellectual Disabilities, Seizure Disorder, Osteoporosis, Dysphagia, Constipation (Individual #2) **When DSP were asked, if the Individual is diagnosed with Aspiration, as well as a series of questions specific to the DSP's knowledge of Aspiration, the following was reported:**	**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?)*: →	

skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and	• DSP #502 stated, "He is a silent aspirator. He will put his head down and does not respond." Per MERP for Aspiration, Individual's "main symptom is coughing or difficulty breathing." (Individual #2) **When DSP were asked, if the Individual had Seizure Disorder, as well as a series of questions specific to the DSP's knowledge of the Seizure Disorder, the following was reported:** • DSP #502 stated, "Track it, if it goes for more than 3 minutes to take him in. We call the nurse and she informs us to take him in." Per MERP for Seizure, "…seek Emergency Department if he has 3 or more seizures within 24 hours or seizures last greater than 20 minutes." (Individual #2) **When DSP were asked, if the Individual had Limited Ambulation / Limited Mobility, as well as a series of questions specific to the DSP's knowledge of the Limited Ambulation / Limited Mobility, the following was reported:** • DSP 502 stated, "No." Per eCHAT, Individual has a Health Care Plan for Skin and Wound due to immobility. (Individual #2) **When DSP were asked, what are the steps you need to take before assisting an individual with PRN medication, the following was reported:** • DSP #510 stated, "Notify of time to give him medications, make sure all medication match the MAR." *Per DDSD standards 13.2.12 Medication Delivery DSP not related to the*		

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. 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. The competency level of the training is based on the IST section of the ISP. The person should be present for and involved in IST whenever possible. Provider Agencies are responsible for tracking of IST requirements. 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. 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.	*Individual must contact nurse prior to assisting with medication.* (Individual #2) **When DSP were asked to give examples of Abuse, Neglect and Exploitation, the following was reported:** • DSP #502 stated, "I'm not sure about that one." DSP's response with regards to Exploitation.		

Tag # 1A43.1 General Events Reporting: Individual Reporting	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 19: Provider Reporting Requirements: 19.2 General Events Reporting (GER):** The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows: DD Waiver Provider Agencies approved to provide Customized In- Home Supports,	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 3 of 8 individuals. **The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within the required timeframe:** **Individual #2** • General Events Report (GER) indicates on 8/6/2019 the Individual was taken to ER. (Emergency Services). GER was approved 8/14/2019. • General Events Report (GER) indicates on 8/31/2019 the Individual was taken to ER. (Emergency Services). GER was approved 9/5/2019.	**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?)*: →	

Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use GER in the Therap system. DD Waiver Provider Agencies referenced above are responsible for entering specified information into the GER section of the secure website operated under contract by Therap according to the GER Reporting Requirements in Appendix B GER Requirements. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap. GER does not replace a Provider Agency's obligations to report ANE or other reportable incidents as described in Chapter 18: Incident Management System. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities. **Appendix B GER Requirements:** DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting: *Effective immediately*, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau. No alternative methods for reporting are permitted. **<u>The following events need to be reported in the Therap GER:</u>** 1. Emergency Room/Urgent Care/Emergency Medical Services 2. Falls Without Injury	**Individual #3** • General Events Report (GER) indicates on 3/18/2019 the Individual was taken to ER (Emergency Services). GER was approved 3/22/2019. **Individual #4** • General Events Report (GER) indicates on 11/30/2018 the Individual was AWOL (Missing Person) GER was approved 12/13/2018. • General Events Report (GER) indicates on 5/29/2019 the Individual was Injured (Injury). GER was approved 6/3/2019. **The following events were not reported in the General Events Reporting System as required by policy:** **Individual #3** • Documentation reviewed indicates on 6/3/2019 the Individual was taken to hospital (Emergency Room). No GER was found.		

3. Injury (including Falls, Choking, Skin Breakdown and Infection) 4. Law Enforcement Use 5. Medication Errors 6. Medication Documentation Errors 7. Missing Person/Elopement 8. Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission 9. PRN Psychotropic Medication 10. Restraint Related to Behavior 11. Suicide Attempt or Threat **Entry Guidance:** Provider Agencies must complete the following sections of the GER with detailed information: profile information, event information, other event information, general information, notification, actions taken or planned, and the review follow up comments section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.			

Standard of Care	**Deficiencies**	**Agency Plan of Correction, On-going QA/QI and Responsible Party**	**Date Due**
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Condition of Participation Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: • 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 4 of 8 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):*** **Dental Exam:**	**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?)*: →	

suggestion. This includes, but is not limited to: • 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; • clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; • health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and • recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 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: • 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. • The information will be focused on the specific area of concern by the person/guardian. Alternatives should be	20 Individual #2 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. *21* Individual #8 - As indicated by collateral documentation reviewed, exam was completed on 1/24/2019. Follow-up was to be completed. No evidence of follow-up found. *(Note: Exam was scheduled for 11/6/2019 during on-site survey.)* **Neurology:** 3.1 Individual #1 - As indicated by collateral documentation reviewed, exam was completed on 3/29/2019. Follow-up was to be completed in 6 months. No evidence of follow-up found. *(Note: Exam was scheduled for 11/8/2019 during on-site survey.)* **Psychiatry:** 22 Individual #4 - As indicated by collateral documentation reviewed, the exam was completed on 8/13/2019. No evidence of exam results was found.		

presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 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. 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. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 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. 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. 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. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 *Health Passport and Physician Consultation Form:*** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. **Chapter 10: Living Care Arrangements (LCA) Living Supports-Supported Living: 10.3.9.6.1 Monitoring and Supervision** 4. Ensure and document the following: 1. The person has a Primary Care			

Practitioner. 2. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist. 3. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist. 4. The person receives a hearing test as recommended by a licensed audiologist. 5. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist. 5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine). **10.3.10.1 Living Care Arrangements (LCA) Living Supports-IMLS: 10.3.10.2 General Requirements:** 9 . Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and annual dental checkup by a licensed dentist). **Chapter 13 Nursing Services: 13.2.3 General Requirements:** Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information.			

Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 22:Quality Improvement Strategy (QIS):** A QIS at the provider level is directly linked to the organization's service delivery approach or underlying provision of services. To achieve a higher level of performance and improve quality, an organization is required to have an efficient and effective QIS. The QIS is required to follow four key principles: • quality improvement work in systems and processes; • focus on participants; • focus on being part of the team; and • focus on use of the data. As part of a QIS, Provider Agencies are required to evaluate their performance based on the four key principles outlined above. Provider Agencies are required to identify areas of improvement, issues that impact quality of services, and areas of non-compliance with the DD Waiver Service Standards or any other program requirements. The findings should help inform the agency's QI plan.	Based on record review, the Agency did not maintain or implement a Quality Improvement System (QIS), as required by standards. **Review of information found:** Review of meeting minutes found meeting were not occurring quarterly as required. Meetings were held on: 1. 11/14/2018 2. 12/4/2018 3. 9/25/2019	**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?)*: →	

22.2 QI Plan and Key Performance Indicators (KPI): Findings from a discovery process should result in a QI plan. The QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving goals, and identifying opportunities for improvement. The QI plan describes the processes that the Provider Agency uses in each phase of the QIS: discovery, remediation, and sustained improvement. It describes the frequency of data collection, the source and types of data gathered, as well as the methods used to analyze data and measure performance. The QI plan must describe how the data collected will be used to improve the delivery of services and must describe the methods used to evaluate whether implementation of improvements is working. The QI plan shall address, at minimum, three key performance indicators (KPI). The KPI are determined by DOH-DDSQI) on an annual basis or as determined necessary. ***22.3 Implementing a QI Committee:*** A QI committee must convene on at least a quarterly basis and more frequently if needed. The QI Committee convenes to review data; to identify any deficiencies, trends, patterns, or concerns; to remedy deficiencies; and to identify opportunities for QI. QI Committee meetings must be documented and include a review of at least the following: • Activities or processes related to discovery, i.e., monitoring and recording the findings; • The entities or individuals responsible for conducting the discovery/monitoring process; • The types of information used to measure performance; • The frequency with which performance is measured; and • The activities implemented to improve performance.			

22.4 Preparation of an Annual Report: The Provider Agency must complete an annual report based on the quality assurance (QA) activities and the QI Plan that the agency has implemented during the year. The annual report shall: 1. Be submitted to the DDSD PEU by February 15th of each calendar year. 2. Be kept on file at the agency, and made available to DOH, including DHI upon request. 3. Address the Provider Agency's QA or compliance with at least the following: a. compliance with DDSD Training Requirements; b. compliance with reporting requirements, including reporting of ANE; c. timely submission of documentation for budget development and approval; d. presence and completeness of required documentation; e. compliance with CCHS, EAR, and Licensing requirements as applicable; and f. a summary of all corrective plans implemented over the last 24 months, demonstrating closure with any deficiencies or findings as well as ongoing compliance and sustainability. Corrective plans include but are not limited to: • IQR findings; • CPA Plans related to ANE reporting; • POCs related to QMB compliance surveys; and • PIPs related to Regional Office Contract Management. 4. Address the Provider Agency QI with at least the following: a. data analysis related to the DDSD			

required KPI; and b. the five elements required to be discussed by the QI committee each quarter. **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 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: **(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; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(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 # 1A09 Medication Delivery Routine Medication Administration	**Condition of Participation Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. Including the following on the MAR: 1. The name of the person, a transcription of the physician's or licensed health care provider's orders including the	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of 9/2019 and 10/2019. Based on record review, 2 of 8 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #2 September 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Critic – Acid Clear Ointment (2 times daily) – Blank 9/4, 9 - 30 (7:00 am) and 9/9 - 30 (7:00 pm) • Gold Bond Lotion (2 times daily) – Blank 9/7 - 8 (8:00 pm) • Moisture Barrier Cream (every 12 hours) – Blank 9/7 - 8 (8:00 pm) • Moisturizing Skin Cream 8% (2 times daily) – Blank 9/4 - 30 (8:00 am) 9/4 - 6, 9 - 30 (8:00 pm)	**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?)*: →	

brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; 2. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; 3. Documentation of all time limited or discontinued medications or treatments; 4. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; 5. Documentation of refused, missed, or held medications or treatments; 6. Documentation of any allergic reaction that occurred due to medication or treatments; and 7. For PRN medications or treatments: 1. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; 2. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and 3. documentation of the effectiveness	• Nystatin Cream 100,000 unit/gm (2 times daily) – Blank 9/14 - 15 (8:00 pm) and 9/16 (8:00 am) October 2019 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Cephalexin 500 mg capsule (every 8 hours for 10 days) Individual #3 September 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Multivitamin (1 time daily) – Blank 9/10 (8:00 am) As indicated by the Medication Administration Records the individual is to take Levothyroxine 50mcg, take 1 and ½ tablets (1 time daily). According to the Physician's Orders, Levothyroxine 25 mcg, take 1 ½ tablets is to be taken 1 time daily. Medication Administration Record and Physician's Orders do not match.		

of the PRN medication or treatment. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: the processes identified in the DDSD AWMD training; the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR). **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications.			

Model Custodial Procedure Manual ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: 1. symptoms that indicate the use of the medication, 2. exact dosage to be used, and 3. the exact amount to be used in a 24-hour period.			

Tag # 1A09.1 Medication Delivery PRN Medication Administration	**Condition of Participation Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 1. Including the following on the MAR: 1. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of 09/2019 and 10/2019. Based on record review, 7 of 8 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #1 September 2019 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Acetaminophen 500 mg (PRN) • Chloraseptic Spray (PRN) • Ibuprofen 200 mg (PRN) • Mylanta (PRN) • Nasal Spray (PRN) • Robitussin DM (PRN) • Triple Antibiotic Ointment (PRN)	**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?)*: →	

treatments, and the diagnoses for which the medications or treatments are prescribed; 2. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; 3. Documentation of all time limited or discontinued medications or treatments; 4. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; 5. Documentation of refused, missed, or held medications or treatments; 6. Documentation of any allergic reaction that occurred due to medication or treatments; and 7. For PRN medications or treatments: 1. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; 2. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and 3. documentation of the effectiveness of the PRN medication or treatment.	Individual #2 September 2019 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Acetaminophen 325 mg (PRN) • Chloraseptic Sore Throat Spray (PRN) • Ibuprofen 200 mg (PRN) • Mylanta (PRN) • Nasal Spray (PRN) • Pepto Bismol (PRN) • Robitussin DM (PRN) • Triple Antibiotic Ointment (PRN) Individual #3 September 2019 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 325 mg – PRN – 9/16 (given 1 time) Individual #4 September 2019 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Caladryl Lotion 1%-8% – PRN – 9/2, 3, 7, 9, 12 (given 1 time) & 9/5 (given 2 times).		

Chapter 10 Living Care Arrangements ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: the processes identified in the DDSD AWMD training; the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).	• Hydroxyzine HCL 25 mg – PRN – 9/3, 4, 5, 7, 8, 10, 11, 13 (given 1 time) & 9/1, 9, 12 (given 2 times). Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Acetaminophen (PRN) • Albuterol Inhaler 8.5 mg (PRN) • Chloraseptic Sore Throat Spray (PRN) • Diphenhydramin 2% Topical Cream (PRN) • Ibuprofen 200 mg (PRN) • Nasal Spray (PRN) • Mylanta (PRN) • Robitussin (PRN) • Triple Antibiotic Ointment (PRN) October 2019 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Hydroxyzine HCL 25 mg (PRN) Individual #5 September 2019 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Acetaminophen 325 mg (PRN)		

	• Acetaminophen 500 mg (PRN) • Albuterol Inhaler 8.5 mg (PRN) • Chloraseptic Sore Throat Spray (PRN) • Ibuprofen 200 mg (PRN) • Nasal Spray (PRN) • Mylanta (PRN) • Robitussin DM (PRN) • Robitussin Mucinex DM (PRN) • Sunscreen SPF30 (PRN) • Triple Antibiotic Ointment (PRN) Individual #6 September 2019 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Chloraseptic Spray (PRN) • Ibuprofen 200 mg (PRN) • Nasal Spray (PRN) • Milk of Magnesia (PRN) • Mylanta (PRN) • Pepto Bismal (PRN) • Robitussin (PRN)		

	• Triple Antibiotic Ointment (PRN) • Tylenol 500 mg (PRN) Individual #8 September 2019 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Acetaminophen (PRN) • Chloraseptic Spray (PRN) • Ibuprofen 200 mg (PRN) • Nasal Spray (PRN) • Mylanta (PRN) • Robitussin DM/Mucinex DM (PRN) • Triple Antibiotic Ointment (PRN)		

Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	**Condition of Participation Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 13 Nursing Services: *13.2.12 Medication Delivery:*** Nurses are required to: Be aware of the New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations. Communicate with the Primary Care Practitioner and relevant specialists regarding medications and any concerns with medications or side effects. Educate the person, guardian, family, and IDT regarding the use and implications of medications as needed. Administer medications when required, such as intravenous medications; other specific injections; via NG tube; non-premixed nebulizer treatments or new prescriptions that have an ordered assessment. Monitor the MAR or treatment records at least monthly for accuracy, PRN use and errors. Respond to calls requesting delivery of PRNs from AWMD trained DSP and non-related (surrogate or host) Family Living Provider Agencies. Assure that orders for PRN medications or treatments have: 1. clear instructions for use; 2. observable signs/symptoms or circumstances in which the medication is	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review and interview, the Agency did not maintain documentation of PRN authorization as required by standard for 1 of 8 Individuals. Individual #4 September 2019 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Caladryl Lotion 1%-8% – PRN – 9/2, 3, 7, 9, 12 (given 1 time) & 9/5 (given 2 times). • Hydroxyzine HCL 25 mg – PRN – 9/3, 12 (given 1 time).	**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?)*: →	

to be used or withheld; and 3. documentation of the response to and effectiveness of the PRN medication administered. Monitor the person's response to the use of routine or PRN pain medication and contact the prescriber as needed regarding its effectiveness. Assure clear documentation when PRN medications are used, to include: 1. DSP contact with nurse prior to assisting with medication. 1. The only exception to prior consultation with the agency nurse is to administer selected emergency medications as listed on the Publications section of the DOH-DDSD -Clinical Services Website https://nmhealth.org/about/ddsd/pgsv/clinical/. 2. Nursing instructions for use of the medication. 3. Nursing follow-up on the results of the PRN use. 4. When the nurse administers the PRN medication, the reasons why the medications were given and the person's response to the medication.			

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	**Condition of Participation Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 7 of 8 individual Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Comprehensive Aspiration Risk Management Plan*:*** **1.** Not linked / attached in Therap. (#2) *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* • Not linked / attached in Therap. (#3) *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* • Not linked / attached in Therap. (#8) *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* **Health Care Plans:** ***A1C Levels:***	**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?)*: →	

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 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: • 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:	1. Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Body Mass Index:*** 2. Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 3. Individual #6 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 4. Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Bowel and Bladder Function:*** 5. Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)*		

• 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; • clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; • health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and • recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 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: 1. 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. **2.** 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	***Constipation:*** 6. Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 7. Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Endocrine:*** 8. Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Oral Care:*** 9. Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Paralysis:*** 10. Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap.		

for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting. **Chapter 13 Nursing Services: *13.2.5 Electronic Nursing Assessment and Planning Process:*** The nursing assessment 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. 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. The hierarchy for Nursing Assessment and Planning responsibilities is: Living Supports: Supported Living, IMLS or Family Living via ANS; Customized Community Supports- Group; and Adult Nursing Services (ANS): 1. for persons in Community Inclusion with health-related needs; or 2. if no residential services are budgeted but assessment is desired and health needs may exist. ***13.2.6 The Electronic Comprehensive Health Assessment Tool (e-CHAT)***	*(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Respiratory/Asthma:*** 11. Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Risk for Falls:*** 12. Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Seizure Disorder:*** 13. Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 14. Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 15. Individual #5 - According to Electronic Comprehensive Health Assessment Tool the		

The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person. 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. 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 desired by adding ANS hours for assessment and consultation to their budget. 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. The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections. ***13.2.7 Aspiration Risk Management Screening Tool (ARST)*** ***13.2.8 Medication Administration Assessment Tool (MAAT):*** A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting. 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. Decisions about medication delivery are made by the IDT to promote a person's	individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 16. Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Skin and Wound:*** 17. Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Supports for Hydration:*** 18. Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 19. Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)*		

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. **13.2.9 Healthcare Plans (HCP)*:*** 1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. 2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary 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. ***13.2.10 Medical Emergency Response Plan (MERP):*** The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT	20. Individual #5 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 21. Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* **Medical Emergency Response Plans:** ***A1C Levels:*** 22. Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Aspiration Risk:*** 23. Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 24. Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap.		

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. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation. **Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form.	*(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 25. Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Constipation:*** 21 Individual #8 – According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Endocrine:*** 26. Individual #7 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Paralysis:*** 22 Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Respiratory:***		

	27. Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Risk for Falls:*** 23 Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 24 Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Seizures:*** 25 Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 26 Individual #2 – According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)*		

	27 Individual #5 – According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* 28 Individual #8 – According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)*		

Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider	**Standard Level Deficiency**		
NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS: **A. Duty to report:** **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** **(1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service	Based on record review the Agency did not report suspected abuse, neglect, or exploitation**,** unexpected and natural/expected deaths; or other reportable incidents as required to the Division of Health Improvement. During the on-site survey on 10/7 – 10, 2019, surveyors found evidence of 1 internal agency incident reports, which had not been reported to DHI, as required by regulation. The following internal incidents were reported as a result of the on-site survey: Individual #2 • Incident date 9/2019. Type of incident identified was neglect. Incident was brought to the attention of the Agency by Surveyors. ANE report was filed on 10/7/2019 by DHI/QMB.	**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?)*: →	

provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. **(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form. **(3) Limited provider investigation:** No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation.			

(4) Immediate action and safety planning: Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall: **(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable; **(b)** be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and **(c)** provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057. **(5) Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident. **(6) Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative.			

(7) Case manager or consultant notification by community-based service providers: The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant. **(8) Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation.			

Tag # 1A33.1 Board of Pharmacy - License	**Standard Level Deficiency**		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **Display of License and Inspection Reports** The following are required to be publicly displayed: 1. Current Custodial Drug Permit from the NM Board of Pharmacy 2. Current registration from the consultant pharmacist 3. Current NM Board of Pharmacy Inspection Report	Based on observation, the Agency did not provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report, as required by standard: **Facility (Coyote Canyon Rehabilitation Center):** • Current Custodial Drug Permit from the NM Board of Pharmacy (Location: 10 miles East Navajo Route 9)	**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 # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 10: Living Care Arrangements (LCA) 10.3.6 Requirements for Each Residence:** Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence: has basic utilities, i.e., gas, power, water, and telephone; has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher; has a general-purpose first aid kit; has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift; has water temperature that does not exceed a safe temperature (110^0 F); has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP; has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy; has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; supports environmental modifications and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets,	Based on record review and observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 4 of 4 Living Care Arrangement residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** • General-purpose first aid kit (#1) • Water temperature in home does not exceed safe temperature (120^0 F) • Water temperature in home measured 124.3^0 F (#7) • Emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy (#2, 3, 4, 5, 7, 8) *Note: The following Individuals share a residence:* 1. #2, 4, 5 2. #3, 8	**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?)*: →	

etc.) based on the unique needs of the individual in consultation with the IDT; has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed; has the phone number for poison control within line of site of the telephone; has general household appliances, and kitchen and dining utensils; has proper food storage and cleaning supplies; has adequate food for three meals a day and individual preferences; and has at least two bathrooms for residences with more than two residents.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. Comprehensive documentation of direct service delivery must include, at a minimum: 1. the agency name; 2. the name of the recipient of the service; 3. the location of the service; 4. the date of the service; 5. the type of service; 6. the start and end times of the service; 7. the signature and title of each staff member who documents their time; and 8. the nature of services. 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. A Provider Agency that receives payment for treatment, services or goods must retain all	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 1 of 8 individuals. Individual #3 August 2019 ○ The Agency billed 92 units of Customized Community Supports (Group) (T2021 HBU7) from 8/26/2019 through 8/29/2019. Documentation received accounted for 88 units.	**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?)*: →	

medical and business records relating to any of the following for a period of at least six years from the payment date: 1. treatment or care of any eligible recipient; 2. services or goods provided to any eligible recipient; 3. amounts paid by MAD on behalf of any eligible recipient; and 4. any records required by MAD for the administration of Medicaid. **21.9 Billable Units:** The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: A day is considered 24 hours from midnight to midnight. 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. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. 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: 1. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%). 2. The receiving Provider Agency bills the remaining days up to 340 for the ISP			

year. **21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days. 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. Monthly units can be prorated by a half unit. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit. **21.9.3 Requirements for 15-minute and hourly units**: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following: 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. Services that last in their entirety less than eight minutes cannot be billed.			
Tag # LS26 Supported Living Reimbursement	**Standard Level Deficiency**		

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and h. the nature of services. 3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer. 4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date: a. treatment or care of any eligible recipient; b. services or goods provided to any eligible	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 5 of 8 individuals. Individual #3 June 2019 ○ The Agency billed 1 unit of Supported Living (T2016 HB U5) on 6/2/2019. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. ○ The Agency billed 1 unit of Supported Living (T2016 HB U5) on 6/9/2019. No documentation was found on 6/9/2019 to justify the 1 unit billed. ○ The Agency billed 1 unit of Supported Living (T2016 HB U5) on 6/23/2019. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. ○ The Agency billed 1 unit of Supported Living (T2016 HB U5) on 6/30/2019. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount.	**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?)*: →	

recipient; c. amounts paid by MAD on behalf of any eligible recipient; and d. any records required by MAD for the administration of Medicaid. **21.9 Billable Units:** The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: ▪ A day is considered 24 hours from midnight to midnight. ▪ 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. ▪ The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. ▪ 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: • The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%). • The receiving Provider Agency bills the remaining days up to 340 for the ISP year.	July 2019 ○ The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/1/2019. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. ○ The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/7/2019. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. ○ The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/21/2019. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. ○ The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/28/2019. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation received accounted for 8 hours, which is less than the required amount. August 2019		

21.9.2 Requirements for Monthly Units: For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days. 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. Monthly units can be prorated by a half unit. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit. **21.9.3 Requirements for 15-minute and hourly units**: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following: 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. Services that last in their entirety less than eight minutes cannot be billed.	○ The Agency billed 3 units of Supported Living (T2016 HB U5) on 8/1 – 3, 2019. No documentation was found on 8/1 – 3, 2019 to justify the 3 units billed. ○ The Agency billed 13.5 units of Supported Living (T2016 HB U5) on 8/8 – 21, 2019. No documentation was found on 8/8 – 21, 2019 to justify the 13.5 units billed. Individual #7 June 2019 1. The Agency billed 1 unit of Supported Living (T2016 HB U5) on 6/2/2019. Documentation did not contain the required element on 6/2/2019. Documentation received accounted for 0 units. The required element was not met: 2. The signature or authenticated name of staff providing the service. July 2019 ○ The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/7/2019. No documentation was found on 7/7/2019 to justify the 1 unit billed. Individual #8 June 2019 ○ The Agency billed 30 units of Supported Living (T2016 HB U5) on 6/1 – 30, 2019. No documentation was found on 6/1 – 30, 2019 to justify the 30 units billed. July 2019 ○ The Agency billed 1 unit of Supported Living (T2016 HB U5) on 7/1/2019. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24-hour period must be provided in order to bill a complete unit. Documentation		

	received accounted for 8 hours, which is less than the required amount. August 2019 ○ The Agency billed 7 units of Supported Living (T2016 HB U5) on 8/1 – 7, 2019. No documentation was found on 8/1 – 7, 2019 to justify the 7 units billed.		

Date: January 14, 2020

To: Angelee James, Interim Director
Provider: Coyote Canyon Rehabilitation Center, Inc.
Address: 10 Miles East Navajo Route 9
State/Zip: Brimhall, New Mexico 87310

E-mail Address: ajames@ccrcnm.org
vleslie@ccrcnm.org
ysandoval@ccrcnm.org
skee@ccrcnm.org
mjarvison@ccrcnm.org
lucille.mccabe@ccrcnm.org
jonathan.avery@ccrcnm.org
jjansen@ccrcnm.org

Region: Northwest
Survey Date: October 4 – 10, 2019

Program Surveyed: Developmental Disabilities Waiver

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

Survey Type: Routine

Dear Ms. James:

The Division of Health Improvement Quality Management Bureau has received, reviewed and approved the Plan of Correction specific to Tag #IS30 and Tag #LS26. The supporting documents submitted for these specific tags now closes the Plan of Correction process through the Quality Management Bureau. Now that the QMB POC process is closed, you are still required to move forward with the Directive Corrective Action Plan through the Internal Review Committee (IRC).

Once the agency successfully fulfills the requirements of the IRC, the Division of Health Improvement Quality Management Bureau may conduct a **Verification survey.**

The Quality Management Bureau may conduct a verification survey to ensure deficiencies have been corrected and that systemic Quality Improvement and Quality Assurance processes have been effective at sustaining corrections.

If the Verification survey identifies repeat deficiencies additional sanctions may be put in place by the Internal Review Committee including civil monetary penalties possible monetary fines and/or other sanctions.

Thank you for your cooperation with the Plan of Correction process.

Sincerely,

Monica Valdez, BS

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

Q.20.2.DDW.D2167.1.RTN.07.19.014