Date:	December 5, 2019
To:	Scott Good, State Director
Provider:	Dungarvin New Mexico, LLC
Address:	2309 Renard Place SE, Suite 205
State/Zip:	Albuquerque, New Mexico 87106
E-mail Address:	scgood@dungarvin.com clopezbeck@dungarvin.com kmarshall@dungarvin.com bmyers@dungarvin.com
Region:	Metro & Northwest (Grants)
Survey Date:	November 1 – 7, 2019
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Family Living, Intensive Medical 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; Roxanne Garcia, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Heather Driscoll, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Bernadette Baca, MPA, Healthcare Surveyor, Division of Health improvement/Quality Management Bureau; Crystal Archuleta, BS ED, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Wolf Krusemark, BFA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator; Division of Health Improvement/Quality Management Bureau; Yolanda J. Herrera, RN, Nurse Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau;

Dear Mr. Scott Good;

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:

- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation
- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # 1A20 Direct Support Personnel Training
- Tag # 1A25.1 Caregiver Criminal History Screening
- Tag # 1A09 Medication Delivery Routine Medication Administration
- Tag # 1A09.1 Medication Delivery PRN Medication Administration
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)
- Tag # 1A31 Client Rights/Human Rights

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File (Other Required Documents)
- Tag # 1A08.3 Administrative Case File: Individual Services Plan / ISP Components
- 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 # IS04 Community Life Engagement
- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements
- Tag # IS12 Person Centered Assessment (Inclusion Services)
- Tag # LS14.1 Residential Service Delivery Site Case File (Other Required Documentation)
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A37 Individual Specific Training
- Tag # 1A43.1 General Events Reporting: Individual Reporting
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow up
- 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 # 1A39 Assistive Technology and Adaptive Equipment
- 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

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:	November 1, 2019
Contact:	**Dungarvin New Mexico, LLC** Crystal Lopez Beck, Director **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead / Healthcare Surveyor
On-site Entrance Conference Date:	November 4, 2019
Present:	**Dungarvin New Mexico, LLC** Scott Good, State Director Crystal Lopez Beck, Director **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead / Healthcare Surveyor Heather Driscoll, AA, Healthcare Surveyor Bernadette Baca, MPA, Healthcare Surveyor Monica Valdez, BS, Advanced Healthcare Surveyor
Exit Conference Date:	November 7, 2019
Present:	**Dungarvin New Mexico, LLC** Scott Good, State Director Crystal Lopez Beck, Director Kim Marshall, Director Bernadine Leekela, Director Judy Bencomo, Program Director Christie Smith, Program Director Audy Padilla, Program Director Yacoub Hussein, Program Director Bernadine Moya, Program Director Angielia Prokash, Health Service Coordinator Amanda Martin, Office Program Coordinator Sally Kolf, Office Manager **DOH/DHI/QMB** Kayla R. Benally, BSW, Team Lead / Healthcare Surveyor Lora Norby, Healthcare Surveyor Heather Driscoll, AA, Healthcare Surveyor Bernadette Baca, MPA, Healthcare Surveyor Roxanne Garcia, BA, Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Valerie V. Valdez, MS, Bureau Chief (via phone) **DDSD – Metro Regional Office** Marie Velasco, Social Community Service Coordinator **DDSD – NW Regional Office** Crystal Wright, Regional Director
Administrative Locations Visited:	2 (2309 Renard Place SE, Albuquerque, NM 87106; 825 Roosevelt Avenue, Grants, NM 87020)
Total Sample Size:	18

	1 - *Jackson* Class Members 17 - Non-*Jackson* Class Members 12 - Supported Living 4 - Family Living 1 - Intensive Medical Living Supports 1 - Customized In-Home Supports 14 - Customized Community Supports 1 - Community Integrated Employment
Total Homes Visited	13
❖ Supported Living Homes Visited	9 *Note: The following Individuals share a SL residence:* ➢ #1, 11 ➢ #5, 9 ➢ #6, 7
❖ Family Living Homes Visited	3 (One home not visited due to family emergency)
❖ Intensive Medical Homes Visited	1
Persons Served Records Reviewed	18
Persons Served Interviewed	7
Persons Served Observed	6 *(Six Individuals chose not to participate in the interview process)*
Persons Served Not Seen and/or Not Available	5
Direct Support Personnel Records Reviewed	135
Direct Support Personnel Interviewed	22 (*One Service Coordinator was interviewed as a DSP)*
Substitute Care/Respite Personnel Records Reviewed	5
Service Coordinator Records Reviewed	7
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%:

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

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

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

- **1A20 -** Direct Support Personnel Training
- **1A22 -** Agency Personnel Competency

- **1A37 –** Individual Specific Training

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

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

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

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

Attachment C

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

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

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Bureau Chief **within 10 business days** of receipt of the final Report of Findings **(*Note: No extensions are granted for the IRF)*.**
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:

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

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

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

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

Non-Compliance:

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

1. Your Report of Findings includes 17 or more 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: **Dungarvin NM, LLC – Metro and Northwest (Grants) Region**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Supported Living, Family Living, Intensive Medical Living; Customized In-Home Supports, Customized Community Supports, Community Integrated Employment Services
Survey Type: Routine
Survey Date: **November 1 – 7, 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: 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	Based on record review the Agency did not maintain a complete and confidential case file at the administrative office for 4 of 18 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current **Positive Behavioral Support Plan:** • Not Current (#15) **Speech Therapy Plan (Therapy Intervention Plan TIP):** • Not Found (#5) **Occupational Therapy Plan (Therapy Intervention Plan TIP):** • Not Found (#6) **Physical Therapy Plan (Therapy Intervention Plan TIP):** • Not Found (#6) **IDT Meeting Minutes:** • Not Found (#13)	**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. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. ***20.5.1 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: a. to implement the recommendation; b. to create an action plan and revise the ISP, if necessary; or c. not to implement the recommendation currently. 3. All DD Waiver Provider Agencies participate in information gathering, IDT meeting attendance, and accessing supplemental resources if needed and desired. 4. The CM ensures that the Team Justification Process is followed and complete.			

Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	Standard Level Deficiency		
NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY. **NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS.** **NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.** Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 6 Individual Service Plan:** The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP. ***6.5.2 ISP Revisions:*** The ISP is a dynamic document that changes with the person's desires, circumstances, and need. IDT members must collaborate and request an IDT meeting from the CM when a need to modify the ISP arises. The CM convenes the IDT within ten days of receipt of any reasonable request to convene the team, either in person or through teleconference. **6.6 DDSD ISP Template:** The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e. an acknowledgement of receipt of specific information) and other	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 18 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Teaching and Support Strategies:** ***Individual #13:*** *TSS not found for the following Work Outcome Statement / Action Steps:* • "…will create a weekly schedule on his tablet." • "…will download new apps of interest." • "…will select and participate in at least 5 community activities of his choice weekly through ISP year." *TSS not found for the following Fun Outcome Statement / Action Steps:* • "…will visit art n craft stores to select materials to use for his art projects."	**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?)*: →	

elements depending on the age of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use in order to better demonstrate required elements of the PCP process and ISP development. The ISP is completed by the CM with the IDT input and must be completed according to the following requirements: 1. DD Waiver Provider Agencies should not recommend service type, frequency, and amount (except for required case management services) on an individual budget prior to the Vision Statement and Desired Outcomes being developed. 2. The person does not require IDT agreement/approval regarding his/her dreams, aspirations, and desired long-term outcomes. 3. When there is disagreement, the IDT is required to plan and resolve conflicts in a manner that promotes health, safety, and quality of life through consensus. Consensus means a state of general agreement that allows members to support the proposal, at least on a trial basis. 4. A signature page and/or documentation of participation by phone must be completed. 5. The CM must review a current Addendum A and DHI ANE letter with the person and Court appointed guardian or parents of a minor, if applicable. **6.6.3 Additional Requirements for Adults:** Because children have access to other funding sources, a larger array of services are available to adults than to children through the DD Waiver. (See Chapter 7: Available Services and Individual Budget Development). The ISP Template for adults is also more extensive,			

including Action Plans, Teaching and Support Strategies (TSS), Written Direct Support Instructions (WDSI), and Individual Specific Training (IST) requirements. **6.6.3.1. Action Plan:** Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes. Multiple service types may be included in the Action Plan under a single Desired Outcome. Multiple Provider Agencies can and should be contributing to Action Plans toward each Desired Outcome. 1. Action Plans include actions the person will take; not just actions the staff will take. 2. Action Plans delineate which activities will be completed within one year. 3. Action Plans are completed through IDT consensus during the ISP meeting. 4. Action Plans must indicate under "Responsible Party" which DSP or service provider (i.e. Family Living, CCS, etc.) are responsible for carrying out the Action Step. **6.6.3.2 Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI):** After the ISP meeting, IDT members conduct a task analysis and assessments necessary to create effective TSS and WDSI to support those Action Plans that require this extra detail. All TSS and WDSI should support the person in achieving his/her Vision. **6.6.3.3 Individual Specific Training in the ISP:** The CM, with input from each DD Waiver Provider Agency at the annual ISP meeting, completes the IST requirements section of the ISP form listing all training needs specific to the individual. Provider Agencies bring their proposed IST to the annual meeting. The IDT			

must reach a consensus about who needs to be trained, at what level (awareness, knowledge or skill), and within what timeframe. (See Chapter 17.10 Individual-Specific Training for more information about IST.) **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.			

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: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 2 of 18 Individuals. Review of the Agency individual case files revealed the following items were not found: **Residential Case File:** **Supported Living Progress Notes/Daily Contact Logs:** • Individual #5 - None found for 11/3/2019. *(Date of home visit: 11/5/2019)* • Individual #14 - None found for 11/1 – 5, 2019. *(Date of home visit: 11/6/2019)* **Administrative Case File:** **Family Living Progress Notes/Daily Contact Logs:** • Individual #14 – *Review of progress notes / daily contact logs for 7/1 – 31, 2019 indicated the agency was not documenting the daily narrative of the Individuals activities, as notes for each day contained the same narrative:* • *"…was sleeping, woke up, showered, make his bed, got ready, went to dayhab." (Per NMAC 8.302.1.17 Record Keeping and Documentation Requirements:…"A. Detail required in records: Provider records must be sufficiently detailed…")*	**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?)*: →	

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.			

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.	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 5 of 18 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 #1 • None found regarding: Live Outcome/Action Step: "…will mark the weekly chart using sticker or stamp" for 7/2019 - 9/2019. Action step is to be completed 2 times per week. Individual #12 • None found regarding: Live Outcome/Action Step: "Will choose day/task" for 7/2019. Action step is to be completed 1 time per week. *Note: Document maintained by the provider was blank.* • None found regarding: Live Outcome/Action Step: "Will complete chosen task" for 7/2019. Action step is to be completed 1 time per week. *Note: Document maintained by the provider was blank.* • None found regarding: Live Outcome/Action Step: "…will choose meal" for 8/2019 -	**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?)*: →	

The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; 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.	9/2019. Action step is to be completed 1 time per week. • None found regarding: Live Outcome/Action Step: "…will complete meal preparation task" for 8/2019 - 9/2019. Action step is to be completed 1 time per week. • None found regarding: Fun Outcome/Action Step: "…will decide the social activity" for 8/2019 - 9/2019. Action step is to be completed 1 time per month. • None found regarding: Fun Outcome/Action Step: "…will be attended chosen activity" for 8/2019 - 9/2019. Action step is to be completed 1 time per month. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • None found regarding: Fun Outcome/Action Step: "…will select the movie or book" for 7/2019 - 9/2019. Action step is to be completed 2 times per week. • None found regarding: Fun Outcome/Action Step: "…will check out the material he has chosen" for 7/2019 - 9/2019. Action step is to be completed 2 times per week. Individual #7 • None found regarding: Work Outcome/Action Step: "…will research opportunities that she shows interest in, i.e., daycares, gardening, hair salons" for 7/2019 - 9/2019. Action step is to be completed 1 time per month. Individual #10		

DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.	• None found regarding: Work Outcome/Action Step: "…through use of low-tech devices, make a choice of what places she wants to see" for 7/2019 - 9/2019. Action step is to be completed 1 time per month. • None found regarding: Work Outcome/Action Step: "…will go to the chosen activity" for 7/2019 – 9/2019. Action step is to be completed every other month. Individual #12 • No Outcomes or DDSD exemption/decision justification found for Customized Community Supports, Individual (H2021 HB UI) 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." Individual #14 • None found regarding: Fun Outcome/Action Step: "…will chose an event that he has planned for the group" for 7/2019 - 9/2019. Action step is to be completed 1 time per month. • None found regarding: Fun Outcome/Action Step: "…will participate in the activity chosen" for 7/2019 – 9/2019. Action step is to be completed 1 time per month.		

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. 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	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 7 of 18 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 #1 • According to the Live Outcome; Action Step for "…will choose a chore" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2019 - 9/2019. • According to the Live Outcome; Action Step for "…will gather the necessary supplies" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2019 - 9/2019 • According to the Live Outcome; Action Step for "…will complete the chore" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2019 - 9/2019 Individual #2	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; 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	• According to the Live Outcome; Action Step for "…will look for new desired recipes to create" 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 8/2019 - 9/2019. • According to the Live Outcome; Action Step for "…will research to take a trip to see a NASCAR Race" 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 9/2019. Individual #4 • According to the Live Outcome; Action Step for "…will participate in his hygiene / self-care tasks" is to be completed 1 time per day. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2019 - 9/2019. Individual #7 • According to the Live Outcome; Action Step for "…will choose a recipe to add to her book" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2019 - 9/2019 Individual #17 • According to the Fun Outcome; Action Step for "…will research upcoming events and activities" 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 9/2019. • According to the Fun Outcome; Action Step for "…will invite peers to attend activities with her" is to be completed 2 times per month.		

of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 8. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 9. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 11. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 12. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 13. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 14. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from	Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2019. • According to the Fun Outcome; Action Step for "…will attend events" 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 9/2019. **Intensive Medical Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #10 • According to the Live Outcome; Action Step for "…will build a book of choices she would like to make regular choice from" 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 - 9/2019. • According to the Live Outcome; Action Step for "…will use her low-tech system to make regular choices of things that she wants" 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 - 9/2019. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #14 • According to the Work/Learn Outcome; Action Step for "…will find a math book or tablet program to see what skills level that he can begin at" is to be completed 1 time per week. Evidence found indicated it was not being		

services.	completed at the required frequency as indicated in the ISP for 9/2019. • According to the Work/Learn Outcome; Action Step for "…will follow through in the chapter for math skills to then test at that level" is to be completed 1 – 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2019.		

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 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: a. purposeful and meaningful work; b. substantial and sustained opportunity for optimal health; c. self-empowerment; d. personalized relationships; e. skill development and/or maintenance; and f. social, educational, and community inclusion activities that are directly linked to the vision, Desired Outcomes and Action Plans stated in the person's	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 4 of 18 Individuals. Review of the individual case files found there is no individualized schedule that can be modified 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 (#1, 7, 12) • Not Individualized (#17)	**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?)*: →	

ISP. 2. 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: a. individualized supports for each person; b. promotion of community membership and contribution; c. use of human and social capital to decrease dependence on paid supports; and d. 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 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.	Based on record review, the Agency did not complete written status reports as required for 17 of 18 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 10/2018 – 10/2019. Semi-Annual Report 4/2019 – 8/2019; Date Completed: 11/7/2019; ISP meeting held on 9/5/2019).* • Individual #2 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 3/2018 – 3/2019. Semi-Annual Report 3/24/2018 – 10/31/2018; Date Completed: 10/31/2018; ISP meeting held on 11/1/2018).* • Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 11/2018 – 10/2019. Semi-Annual Report 5/2019 – 6/2019; Date Completed: 6/25/2019; ISP meeting held on 6/25/2019).* • Individual #7 - None found for 10/2018 - 11/2018. *(Term of ISP 4/2018 – 4/2019. ISP meeting held on 12/6/2018).* • Individual #9 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/2018 – 9/2019. Semi-Annual Report 4/2019 – 5/2019; Date Completed: 6/4/2019; ISP meeting held on 6/4/2019).* • Individual #12 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 8/2018 – 8/2019. Semi-Annual Report 1/2019*	**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?)*: →	

DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.	*– 7/2019; Date Completed: 11/7/2019; ISP meeting held on 2/5/2019).* • Individual #13 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/2018 – 10/2019. Semi-Annual Report 10/01/2018 – 6/30/2019; Date Completed: 7/29/2019; ISP meeting held on 7/10/2019).* • Individual #17 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/2018 – 9/2019. Semi-Annual Report 9/2018 – 5/2019; Date Completed: 6/25/2019; ISP meeting held on 6/12/2019).* **Family Living Semi- Annual Reports:** • Individual #14 - None found for 10/2018 - 4/2019 and 4/2019 – 6/2019. *(Term of ISP 10/2018 – 10/2019. ISP meeting held on 7/7/2019).* • Individual #16 - None found for 10/25/2018 – 10/30/2018. Report covered *11/1/2018 – 4/1/2019*. *(Term of ISP 10/25/2018 – 10/24/2019. ISP meeting held on 7/18/2018). (Per regulations reports must coincide with ISP term).* **Customized In-Home Supports Semi-Annual Reports:** • Individual #8 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 6/2018 – 6/2019. Semi-Annual Report 2/2019-4/2019; Date Completed: 11/7/2019; ISP meeting held on 5/7/2019).* **Customized Community Supports Semi-Annual Reports** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/2018 – 10/2019. Semi-Annual Report*		

Chapter 19: Provider Reporting Requirements 19.5 Semi-Annual Reporting: The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDSD for QA activities. Semi-annual reports are required as follows: 1. DD Waiver Provider Agencies, except AT, EMSP, Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports. 2. A Respite Provider Agency must submit a semi-annual progress report to the CM that describes progress on the Action Plan(s) and Desired Outcome(s) when Respite is the only service included in the ISP other than Case Management, for an adult age 21 or older. 3. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days). 4. The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting. 5. Semi-annual reports must contain at a minimum written documentation of: a. the name of the person and date on each page; b. the timeframe that the report covers; c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering;	*4/2019 – 8/2019; Date Completed: 11/7/2019; ISP meeting held on 9/5/2019).* • Individual #7 - None found for 4/2019 - 9/2019. *(Term of ISP 4/2019 - 4/2020).* Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/2018 - 4/2019. Semi-Annual Report 4/4/2018 – 1/24/2019; Date Completed: 1/24/2019; ISP meeting held on 12/6/2018).* • Individual #9 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/2018 – 9/2019. Semi-Annual Report 4/2019 – 5/2019; Date Completed: 6/4/2019; ISP meeting held on 6/4/2019).* • Individual #12 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 8/2018 – 8/2019. Semi-Annual Report 1/2019 – 7/2019; Date Completed: 11/7/2019; ISP meeting held on 2/5/2019).* • Individual #13 - None found for 10/2018 - 4/2019 and 4/2019 – 6/2019. *(Term of ISP 10/2018 – 10/2019. ISP meeting held on 7/10/2019).* • Individual #14 - None found for 10/2018 - 4/2019 and 4/2019 – 6/2019. *(Term of ISP 10/2018 – 10/2019. ISP meeting held on 7/7/2019).* • Individual #17 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/2018 – 9/2019. Semi-Annual Report 9/2018 – 5/2019; Date Completed: 6/6/2019; ISP meeting held on 6/12/2019).* **Nursing Semi-Annual Reports:**		

d. a description of progress towards Desired Outcomes in the ISP related to the service provided; e. a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing); f. significant changes in routine or staffing if applicable; g. unusual or significant life events, including significant change of health or behavioral health condition; h. the signature of the agency staff responsible for preparing the report; and i. any other required elements by service type that are detailed in these standards.	• Individual #2 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 3/2018 – 3/2019. Semi-Annual Report 10/1/2018 – 12/31/2018; Date Completed: 1/14/2019; ISP meeting held on 11/1/2018).* • Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 11/2018 – 10/2019. Semi-Annual Report 6/2017 – 6/2019; Date Completed: 6/24/2019; ISP meeting held on 6/25/2019).* • Individual #5 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 1/2018- 1/2019. Semi-Annual Report 7/2018 – 9/2018; Date Completed: 10/23/2019; ISP meeting held on 9/16/2018).* • Individual #6 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 6/2018- 6/2019. Semi-Annual Report 12/2018 – 2/2019; Date Completed: 3/11/2019; ISP meeting held on 3/1/2019).* • Individual #7 - None found for 4/2019 - 9/2019. *(Term of ISP 4/2019 – 4/2020).* None found for 9/2018 – 11/2018. *(Term of ISP 4/2018 – 4/2019. ISP meeting held on 12/6/2018).* • Individual #9 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/2018 – 9/2019. Semi-Annual Report 3/2/2019 – 6/1/2019; Date Completed: 6/5/2019; ISP meeting held on 6/4/2019).* • Individual #10 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 5/2018 – 5/20/19. Semi-Annual Report 12/2018 – 2/28/2019; Date Completed: 3/22/2019; ISP meeting held on 2/5/2019).*		

	• Individual #11 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 12/2018 – 11/2019. Semi-Annual Report 4/10/2019 – 9/6/2019; Date Completed: 11/6/2019; ISP meeting held on 9/9/2019).* • Individual #13 - None found for 10/2018 – 4/2019. *(Term of ISP 10/2018 – 10/2019).* Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/2018 – 10/2019. Semi-Annual Report 4/2019 – 6/2019; Date Completed: 11/6/2019; ISP meeting held on 7/10/2019).* • Individual #17 - None found for 9/2018 - 10/2018. Report covered *11/2018 – 5/2019*. *(Term of ISP 9/2018 – 9/2019). (Per regulations reports must coincide with ISP term).* Report not completed 14 days prior to the Annual ISP meeting. *(Semi-Annual Report 6/2018–– 8/2019; Date Completed: 6/11/2019; ISP meeting held on 6/12/2019).* • Individual #18 - None found for 4/16/2019 – 5/2/2019. Report covered *5/3/2019 – 11/3/2019*. *(Term of ISP 4/16/2019 – 4/15/2020). (Per regulations reports must coincide with ISP term).* Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/16/2018 – 4/2019. Semi-Annual Report 4/16/2018 – 1/9/2019; Date Completed: 3/18/2019; ISP meeting held on 1/9/2019).*		

Tag # IS12 Person Centered Assessment (Community Inclusion)	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 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. **11.4 Person Centered Assessments (PCA) and Career Development Plans**: Agencies who are providing CCS and/or CIE to people with I/DD are required to complete a person-centered assessment. A person-centered assessment (PCA) is an instrument used to identify individual needs and strengths to be addressed in the person's ISP. A PCA is a PCP tool that is intended to be used for the service agency to get to know the person whom they are supporting. It should be used to guide services for the person. A career development plan, developed by the CIE Provider Agency, must be in place for job seekers or those already working to outline the tasks needed to obtain, maintain, or seek advanced opportunities in employment. For those who are employed, the career development plan addresses topics such as a plan to fade paid supports from the worksite or strategies to improve opportunities for career	Based on record review, the Agency did not maintain a confidential case file for Individuals receiving Inclusion Services for 1 of 18 individual. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Annual Review - Person Centered Assessment (Individual #7)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

advancement. CCS and CIE Provider Agencies must adhere to the following requirements related to a PCA and Career Development Plan: 5. A person-centered assessment should contain, at a minimum: a. information about the person's background and status; b. the person's strengths and interests; c. conditions for success to integrate into the community, including conditions for job success (for those who are working or wish to work); and d. support needs for the individual. 6. The agency must have documented evidence that the person, guardian, and family as applicable were involved in the person-centered assessment. 7. Timelines for completion: The initial PCA must be completed within the first 90 calendar days of the person receiving services. Thereafter, the Provider Agency must ensure that the PCA is reviewed and updated annually. An entirely new PCA must be completed every five years. If there is a significant change in a person's circumstance, a new PCA may be required because the information in the PCA may no longer be relevant. A significant change may include but is not limited to: losing a job, changing a residence or provider, and/or moving to a new region of the state. 8. If a person is receiving more than one type of service from the same provider, one PCA with information about each service is acceptable. 9. Changes to an updated PCA should be signed and dated to demonstrate that the assessment was reviewed. 10. A career development plan is developed by the CIE provider and can be a separate			

document or be added as an addendum to a PCA. The career development plan should have specific action steps that identify who does what and by when. **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: 15. 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.			

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. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.	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 8 of 17 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 (#2, 6, 7) **ISP Teaching and Support Strategies:** ***Individual #1:*** *TSS not found for the Live Outcome Statement / Action Steps:* • "…will gather the food items and cook meal." ***Individual #2*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "… will practice good cooking, hygiene and wearing gloves during preparation." *TSS not found for the following Fun Outcome Statement / Action Steps:* • "… will research to take a trip to see a NASCAR race." • "…will visit the Unser Racing museum." • "… would like to check out some races at the Sandia Motor Speedway." ***Individual #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?)*: →	

5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. 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	*TSS not found for the following Live Outcome Statement / Action Steps:* • "… will make decorations." • "…will decorate his home with a holiday theme." **Healthcare Passport:** • Not Found (#1, 14, 16) **Medical Emergency Response Plans:** • Paralysis (#17)		

reason and whenever there is a change to contact information contained in the IDF. **Chapter 13: Nursing Services: 13.2.9 Healthcare Plans (HCP)*:*** 1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. 2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary **13.2.10 *Medical Emergency Response Plan (MERP):*** 1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP. 2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.			

Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)	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: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 4 of 17 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **Positive Behavioral Supports Plan:** • Not Found (#17) • Not Current (#7) **Behavior Crisis Intervention Plan:** • Not Found (#4) • Not Current (#6, 7)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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.			

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	**Condition of Participation 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) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports. 1. DSP/DSS must successfully: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in 17.10 Individual-Specific Training below. b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14 c. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements d. Complete and maintain certification in First Aid and CPR. The training	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not ensure Orientation and Training requirements were met for 44 of 135 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: **First Aid:** • Not Found (#505, 506, 522, 536, 543, 552, 553, 557, 563, 569, 570, 571, 601, 611, 625, 626) • Expired (#500, 502, 521, 524, 528, 529, 532, 535, 539, 544, 547, 554, 558, 568, 585, 588, 599, 613, 618, 622, 627, 630, 631, 633) **CPR:** • Not Found (#522, 536, 543, 552, 553, 557, 563, 569, 570, 571, 601, 625, 626) • Expired (#500, 502, 521, 524, 528, 529, 532, 535, 539, 544, 547, 554, 558, 568, 585, 588, 599, 613, 618, 622, 627, 630, 631, 633) **Assisting with Medication Delivery:** • Not Found (#500, 509, 601)	**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?)*: →	

materials shall meet OSHA requirements/guidelines. e. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). f. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using EPR. Agency DSP and DSS shall maintain certification in a DDSD-approved system if any person they support has a BCIP that includes the use of EPR. g. Complete and maintain certification in a DDSD-approved medication course if required to assist with medication delivery. h. Complete training regarding the HIPAA. 2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings and be on shift with a DSP who has completed the relevant IST. **17.1.2 Training Requirements for Service Coordinators (SC):** Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports. 1. A SC must successfully: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported, and as outlined in the 17.10 Individual-Specific Training below. b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14.	• Expired (#617, 618, 622, 623, 627, 630, 633, 638)		

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

Tag # 1A22 Agency Personnel Competency	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:*** 1. RNs and LPNs are required to provide Individual Specific Training (IST) regarding HCPs and MERPs. 2. The agency nurse is required to deliver and document training for DSP/DSS regarding the healthcare interventions/strategies and MERPs that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee as described in Chapter 17.10 Individual-Specific Training. **Chapter 17: Training Requirement** **17.10 Individual-Specific Training:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 3 of 22 Direct Support Personnel. **When DSP were asked, if the Individual had a Positive Behavioral Supports Plan (PBSP), have you been trained on the PBSP and what does the plan cover, the following was reported:** • DSP #509 stated, "I don't think so, I haven't seen … for a minute now. No support plan in book." According to the Individual Specific Training Section of the ISP the Individual requires a Positive Behavioral Supports Plan. (Individual #11) **When DSP were asked, if the Individual's had Medical Emergency Response Plans and where could they be located, the following was reported, the following was reported:** • DSP #509 stated, "Nope, no MERPs." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Aspiration (Individual #11) **When DSP were asked, if the Individual had any food and / or medication allergies that could be potentially life threatening, the following was reported:** • DSP #568 stated, "He does not." As indicated by the Electronic Comprehensive Health Assessment Tool, the individual is allergic to	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported. 1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends. 2. IST for therapy-related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher. 3. The competency level of the training is based on the IST section of the ISP. 4. The person should be present for and involved in IST whenever possible. 5. Provider Agencies are responsible for tracking of IST requirements.	Divalproex Sodium and Penicillin. (Individual #3) **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 #568 stated, "No." According to e-CHAT, the Individual has a diagnosis of Seizures. (Individual #3) **When Direct Support Personnel were asked, what State Agency do you report suspected Abuse, Neglect or Exploitation, the following was reported:** • DSP #586 stated, "I think it's the State of New Mexico." Staff was not able to identify the State Agency as Division of Health Improvement.		

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

Tag # 1A25.1 Caregiver Criminal History Screening	Condition of Participation Level Deficiency		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **A. General:** The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (Amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider] to impose appropriate administrative sanctions and penalties. **B. Exception:** A caregiver or hospital caregiver applying for employment or contracting services with a care provider within twelve (12) months of the caregiver's or hospital caregiver's most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested.	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 documentation indicating Caregiver Criminal History Screening was completed as required for 2 of 146 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Direct Support Personnel (DSP):** • #509 – Date of hire 6/4/2019. • #631 – Date of hire 5/28/2019.	**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?)*: →	

C. Conditional Employment: Applicants, caregivers, and hospital caregivers who have submitted all completed documents and paid all applicable fees for a nationwide and statewide criminal history screening may be deemed to have conditional supervised employment pending receipt of written notice given by the department as to whether the applicant, caregiver or hospital caregiver has a disqualifying conviction. **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **G. Maintenance of Records:** Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes.			

NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.			

Tag # 1A37 Individual Specific 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) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports. 1. DSP/DSS must successfully: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in 17.10 Individual-Specific Training below. b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14 c. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements d. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. e. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). f. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using EPR. Agency DSP and DSS	Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 6 of 142 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Personnel (DSP):** • Individual Specific Training (#617, 629, 635, 639) **Service Coordination Personnel (SC):** • Individual Specific Training (#645, 646)	**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?)*: →	

shall maintain certification in a DDSD-approved system if any person they support has a BCIP that includes the use of EPR. g. Complete and maintain certification in a DDSD-approved medication course if required to assist with medication delivery. h. Complete training regarding the HIPAA. 2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings and be on shift with a DSP who has completed the relevant IST. **17.10 Individual-Specific Training:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques.			

This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported. 1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends. 2. IST for therapy-related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher. 3. The competency level of the training is based on the IST section of the ISP. 4. The person should be present for and involved in IST whenever possible. 5. Provider Agencies are responsible for tracking of IST requirements. 6. Provider Agencies must arrange and ensure that DSP's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are			

hired to arrange for trainings. 7. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan. **17.10.1 IST Training Rosters:** IST Training Rosters are required for all IST trainings: 1. IST Training Rosters must include: a. the name of the person receiving DD Waiver services; b. the date of the training; c. IST topic for the training; d. the signature of each trainee; e. the role of each trainee (e.g., CIHS staff, CIE staff, family, etc.); and f. the signature and title or role of the trainer. 2. A competency based training roster (required for CARMPs) includes all information above but also includes the level of training (awareness, knowledge, or skilled) the trainee has attained. (See Chapter 5.5 Aspiration Risk Management for more details about CARMPs.) 3. A copy of the training roster is submitted to the agency employing the staff trained within seven calendar days of the training date. The original is retained by the trainer.			

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: 1. DD Waiver Provider Agencies approved to provide Customized In- Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use GER in the Therap system. 2. DD Waiver Provider Agencies referenced above are responsible for entering specified information into the GER section of the secure website operated under contract by Therap according to the GER Reporting Requirements in Appendix B GER Requirements. 3. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap. 4. GER does not replace a Provider Agency's obligations to report ANE or other reportable incidents as described in Chapter 18:	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 4 of 18 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 #1** • General Events Report (GER) indicates on 11/29/2018 the Individual was taken to the ER (Emergency Services). GER was approved 12/7/2018 • General Events Report (GER) indicates on 2/1/2019 the Individual was Injured (Injury). GER was approved 2/7/2019. **Individual #6** • General Events Report (GER) indicates on 8/20/2019 the Individual was taken to the ER (Emergency Services). GER was approved 8/28/2019 **Individual #11** • General Events Report (GER) indicates on 8/20/2019 the Individual was taken to the ER (Emergency Services). GER was approved 8/28/2019 **Individual #13** • General Events Report (GER) indicates on 3/6/2019 the Individual had Fallen (Fall without Injury). GER was approved 3/11/2019	**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?)*: →	

Incident Management System. 5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities. **Appendix B GER Requirements:** DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting: 1. *Effective immediately*, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau. 2. No alternative methods for reporting are permitted. **The following events need to be reported in the Therap GER:** • Emergency Room/Urgent Care/Emergency Medical Services • Falls Without Injury • Injury (including Falls, Choking, Skin Breakdown and Infection) • Law Enforcement Use • Medication Errors • Medication Documentation Errors • Missing Person/Elopement • Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission • PRN Psychotropic Medication • Restraint Related to Behavior • Suicide Attempt or Threat **Entry Guidance:** Provider Agencies must complete the following sections of the GER with detailed information: profile information,			

event information, other event information, general information, notification, actions taken or planned, and the review follow up comments 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	**Standard 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: 1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or	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 2 of 18 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:** • Individual #5 - As indicated by collateral documentation reviewed, the exam was completed on 2/21/2018. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found. *(Note: Exam was scheduled for 11/7/2019 during on-site survey.)* **Podiatry** • Individual #13 - As indicated by collateral documentation reviewed, exam was completed on 6/4/2019. Follow-up was to be completed in 3 months. No evidence of follow-up 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?)*: → **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?)*: →	

other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain			

individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with			

DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 *Health Passport and Physician Consultation Form:*** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. **Chapter 10: Living Care Arrangements (LCA) Living Supports-Supported Living: 10.3.9.6.1 Monitoring and Supervision** 4. Ensure and document the following: a. The person has a Primary Care Practitioner. b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist. c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist. d. The person receives a hearing test as recommended by a licensed audiologist.			

e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist. 5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine). **10.3.10.1 Living Care Arrangements (LCA) Living Supports-IMLS: 10.3.10.2 General Requirements:** 9 . Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and annual dental checkup by a licensed dentist). **Chapter 13 Nursing Services: 13.2.3 General Requirements:** 1. Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information.			

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: 1. quality improvement work in systems and processes; 2. focus on participants; 3. focus on being part of the team; and 4. 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. ***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	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 the findings identified during the on-site survey (11/1 – 7, 2019) and as reflected in this report of findings, the Agency had multiple deficiencies noted, including Conditions of Participation out of compliance, which indicates the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.	**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?)*: →	

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: 1. Activities or processes related to discovery, i.e., monitoring and recording the findings; 2. The entities or individuals responsible for conducting the discovery/monitoring process; 3. The types of information used to measure performance; 4. The frequency with which performance is measured; and 5. 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: i. IQR findings; ii. CPA Plans related to ANE reporting; iii. POCs related to QMB compliance surveys; and iv. 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: 1. 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. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: a. 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 treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions 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 10/2019 and 11/2019. Based on record review, 10 of 18 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #1 November 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Calcium/Vitamin D tablet 600/400 (2 times daily) – Blank 11/2 - 4 (8:00 am); 11/2 – 3 (8:00 pm). • Lamotrigine 150 mg (2 times daily) – Blank 11/ 2 - 4 (8:00 am); 11/2 – 3 (8:00 pm). • Onfi 10 mg (1 time daily) – Blank 11/2 - 3, (8:00 pm). • Seroquel 300 mg (1 time daily) – Blank 11/2 - 3 (8:00 pm). • Seroquel XR 150 mg (1 time daily) – Blank 11/2 – 4 (8:00 am). • Topiramate 200 mg (2 times daily) – Blank 11/2 - 4 (8:00 am); 11/2 – 3 (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?)*: →	

treatments; over the counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; d. 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; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. 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; ii. 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 iii. documentation of the effectiveness 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: 1. the processes identified in the DDSD AWMD training;	• Topiramate 200 mg ½ tablet (1 time daily) – Blank 11/2 – 4 (12:00 pm). Individual #3 October 2019 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Dynamic Balance Blend Trace Minerals 1 capsule (1 time daily). Individual #5 October 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Docusate Sodium 100 mg (2 times daily) – Blank 10/30 (8:00 pm). • Lamotrigine 100 mg (2 times daily) – Blank 10/30 (8:00 pm). • Lorazepam 2mg (3 times daily) – Blank 10/27, 28, 30 (8:00 pm). • Melatonin 5mg (1 time daily) – Blank 10/27, 28, 30 (at bedtime). • Olanzapine 10 mg (1 time daily) – Blank 10/27, 28, 30 (at bedtime). • Omega 31,000 mg (2 times daily) – Blank 10/27, 28, 30 (8:00 pm). Individual #6 October 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:		

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. 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.	• Amitiza 24 mcg (2 times daily) – Blank 10/15 (7:00 am); 10/31 (6:00 pm) • Docusate Sodium 100 mg (2 times daily) – Blank 10/15 (6:00 am). • Haloperidol 5 mg (3 times daily) – Blank 10/15 (7:00 am). • Lactulose 20 gm/30 ml (3 times daily) – Blank 10/15 (6:00 am). • Lamotrigine 200 mg (2 times daily) – Blank 10/15 (6:00 am). • Paroxetine 40 mg (2 times daily) – Blank 10/15 (6:00 am). • Senna Laxative 8.6 mg (2 times daily) – Blank 10/15 (8:00 am). Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Trazodone 50 mg (1 time daily) November 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Amitiza 24 mcg (1 time daily) – Blank 11/4 (7:00 am). • Docusate Sodium 100 mg (2 times daily) – Blank 11/4 (6:00 am). • Haloperidol 5 mg (3 times daily) – Blank 11/4 (7:00 am); 11/4 (2:00 pm).		

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24-hour period.	• Lactulose 20 gm/30 ml (3 times daily) – Blank 11/4 (6:00 am); 11/4 (12:00 pm). • Lamotrigine 200 mg (2 times daily) – Blank 11/4 (6:00 am). • Paroxetine 40 mg (2 times daily) – Blank 11/4 (6:00 am). • Senna Laxative 8.6 mg (2 times daily) – Blank 11/4 (8:00 am). Individual #7 October 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Naltrexone 50 mg (1 time daily) – Blank 10/20 - 31 (8:00 am). • Onfi 10 mg (1 time daily) – Blank 10/30 (8:00 pm). • Peridex .12% (2 times daily) – Blank 10/1 – 30 (8:00 am and 8:00 pm). November 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Lactulose 10 GM/1.5 mL (1 time daily) – Blank 11/4 (8:00 am). Medication Administration Records contain the following medications. Medications were not found in the home: • Triamcinolone 55 mcg Individual #9 October 2019		

	Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Calcium Citrate – Vit D Caplet 315 – 200 mg (1 time daily) – Blank 10/22, 30 (9:00 pm). • Depakote Dr 125 mg (1 time daily) – Blank 10/22, 30 (9:00 pm). • Risperidone 1 mg (1 time daily) – Blank 10/22, 30 (9:00 pm). • Vitamin D2 50,000 units (1 time daily) – Blank 10/30 (9:00 am). November 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Calcium Citrate – Vit D Caplet 315 – 200 mg (1 time daily) – Blank 11/4 (9:00 pm). • Depakote Dr 125 mg (1 time daily) – Blank 11/4 (9:00 pm). • Risperidone 1 mg (1 time daily) – Blank 11/4 (9:00 pm). Individual #10 October 2019 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • ES Probiotic 50 billion active cultures (1 time daily). • Nexium Dr 40 mg (1 time daily). • Pro-Stat Sugar Free Liquid 30 ml (1 time daily).		

	Individual #11 October 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Omeprazole Dr 20 mg (2 times daily) – Blank 10/11 (5:00 pm). • Risperidone .5 mg (2 times daily) – Blank 10/11 (8:00 pm). Individual #13 November 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Divaloprex ER 500 mg (2 times daily) – Blank 11/2 (7:00 pm). • Eliquis 5 mg – Blank 11/2 (8:00 pm). • Gabapentin 800 mg (3 times daily) – Blank 11/1, 4, 5 (2:00 pm). • Levetiracetam 750 mg (2 times daily) – Blank 11/2 (7:00 pm). • Oyster Shell Calcium Vita Tablet (3 times daily) – Blank 11/1, 4, 5 (12:00 pm); 11/2 (7:00 pm). Medication Administration Records contain the following medications. Medications were not found in the home: • Aldendronate Sodium 70 mg (1 time a week) Individual #17 October 2019		

	Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Gabapentin 300 mg (3 times daily) – Blank 10/25 (12:00 pm). • Olanzapine 5 mg (1 time daily) – Blank 10/30 (8:00 pm). November 2019 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Gabapentin 300 mg (3 times daily) – Blank 11/5 (12:00 pm).		

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: 1. 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. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: a. 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 treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions 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 10/2019 and 11/2019. Based on record review, 5 of 18 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #3 October 2019 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Aller – 7 (PRN). • Aloe Vera Gel (PRN). • Benadryl 25 mg (PRN). • Tea tree and E Cream (PRN). Individual #4 October 2019 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Lorazepam 2 mg – PRN – 10/4 (given 1 time). Individual #6 October 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?)*: →	

treatments; over the counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; d. 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; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. 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; ii. 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 iii. documentation of the effectiveness 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: 1. the processes identified in the DDSD AWMD training;	No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Magnesium Citrate Solution 150 ml – PRN – 10/8, 31 (given 1 time). Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Acetaminophen 500 mg (PRN). • Cetirizine HCL 10 mg (PRN). • Enema (PRN). • Ibuprofen 200 mg (PRN). • Loperamide 2 mg (PRN) . • Lorazepam .5 mg (PRN). • Magnesium Citrate Solution 150 ml (PRN). • Milk of Magnesia Suspension 30 ml (PRN). • Ondansteron HCL 4 mg (PRN). • Pink Bismuth 30 ml (PRN). • Triple Antibiotic Ointment (PRN). • Tussin DM Cough Syrup 10 ml (PRN) . Individual #7 October 2019 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:		

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).	• Tramadol HCL 50 mg – PRN – 10/23 (given 2 times), 10/25 (given 1 time). Individual #11 October 2019 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Oxycodone – Acetaminophen 5- 325 mg – PRN – 10/11 (given 1 time).		

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 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	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 3 of 18 individual Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Electronic Comprehensive Health Assessment Tool (eCHAT):** • Not Found (#8) ***eCHAT Summary:*** • Not Found (#8) **Medication Administration Assessment Tool*:*** • Not Found (#8) **Aspiration Risk Screening Tool*:*** • Not Found (#8) **Health Care Plans:** ***Paralysis:*** • Individual #17 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. **Medical Emergency Response Plans:** ***Constipation:***	**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?)*: →	

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: 2. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or	• Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Paralysis:*** • Individual #17 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.		

Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are			

modified; and the IDT honors this health decision in every setting. **Chapter 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: 1. Living Supports: Supported Living, IMLS or Family Living via ANS; 2. Customized Community Supports- Group; and 3. Adult Nursing Services (ANS): a. for persons in Community Inclusion with health-related needs; or b. 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)*** 1. The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person. 2. The nurse must see the person face-to-face			

to complete the nursing assessment. Additional information may be gathered from members of the IDT and other sources. 3. An e-CHAT is required for persons in FL, SL, IMLS, or CCS-Group. All other DD Waiver recipients may obtain an e-CHAT if needed or desired by adding ANS hours for assessment and consultation to their budget. 4. When completing the e-CHAT, the nurse is required to review and update the electronic record and consider the diagnoses, medications, treatments, and overall status of the person. Discussion with others may be needed to obtain critical information. 5. 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):*** 1. A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting. 2. After completion of the MAAT, the nurse will present recommendations regarding the level of assistance with medication delivery (AWMD) to the IDT. A copy of the MAAT will be sent to all the team members two weeks before the annual ISP meeting and the original MAAT will be retained in the Provider Agency records. 3. Decisions about medication delivery are made by the IDT to promote a person's maximum independence and community integration. The IDT will reach consensus regarding which criteria the person meets, as indicated			

by the results of the MAAT and the nursing recommendations, and the decision is documented this in the ISP. **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):*** 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. **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.			

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 provider who, in addition to calling the hotline,	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 11/1 - 7, 2019 surveyors found evidence of 1 internal agency incident report, 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 #7 • Incident date 10/2019. Type of incident identified was neglect. Incident was brought to the attention of the Agency by Surveyors. ANE report was filed on 11/5/2019 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?)*: →	

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 # 1A31 Client Rights / Human Rights	Condition of Participation Level Deficiency		
NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review the Agency did not ensure the rights of Individuals was not restricted or limited for 3 of 18 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. <u>No documentation</u> was found regarding Human Rights Approval for the following: • Bed Sensor - No evidence found of Human Rights Committee approval. (Individual #5, 13) • Easy Chair Sensor – No evidence found of Human Rights Committee approval. (Individual #13) • Motion sensors in bedroom and common areas - No evidence found of Human Rights Committee approval. (Individual #5, 17) • External Alarms - No evidence found of Human Rights Committee approval. (Individual #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 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?)*: →	

Chapter 2: Human Rights: Civil rights apply to everyone, including all waiver participants, family members, guardians, natural supports, and Provider Agencies. Everyone has a responsibility to make sure those rights are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to best support the person. **Chapter 3 Safeguards:** ***3.3.1 HRC Procedural Requirements:*** 1. An invitation to participate in the HRC meeting of a rights restriction review will be given to the person (regardless of verbal or cognitive ability), his/her guardian, and/or a family member (if desired by the person), and the Behavior Support Consultant (BSC) at least 10 working days prior to the meeting (except for in emergency situations). If the person (and/or the guardian) does not wish to attend, his/her stated preferences may be brought to the meeting by someone whom the person chooses as his/her representative. 2. The Provider Agencies that are seeking to temporarily limit the person's right(s) (e.g., Living Supports, Community Inclusion, or BSC) are required to support the person's informed consent regarding the rights restriction, as well as their timely participation in the review. 3. The plan's author, designated staff (e.g., agency service coordinator) and/or the CM makes a written or oral presentation to the HRC. 4. The results of the HRC review are reported in writing to the person supported, the guardian, the BSC, the mental health or other specialized therapy provider, and the CM within three working days of the meeting. 5. HRC committees are required to meet at least on a quarterly basis.			

6. A quorum to conduct an HRC meeting is at least three voting members eligible to vote in each situation and at least one must be a community member at large. 7. HRC members who are directly involved in the services provided to the person must excuse themselves from voting in that situation. Each HRC is required to have a provision for emergency approval of rights restrictions based upon credible threats of harm against self or others that may arise between scheduled HRC meetings (e.g., locking up sharp knives after a serious attempt to injure self or others or a disclosure, with a credible plan, to seriously injure or kill someone). The confidential and HIPAA compliant emergency meeting may be via telephone, video or conference call, or secure email. Procedures may include an initial emergency phone meeting, and a subsequent follow-up emergency meeting in complex and/or ongoing situations. 8. The HRC with primary responsibility for implementation of the rights restriction will record all meeting minutes on an individual basis, i.e., each meeting discussion for an individual will be recorded separately, and minutes of all meetings will be retained at the agency for at least six years from the final date of continuance of the restriction. ***3.3.3 HRC and Behavioral Support:*** The HRC reviews temporary restrictions of rights that are related to medical issues or health and safety considerations such as decreased mobility (e.g., the use of bed rails due to risk of falling during the night while getting out of bed). However, other temporary restrictions may be implemented because of health and safety considerations arising from behavioral issues. Positive Behavioral Supports (PBS) are mandated and used when behavioral support is			

needed and desired by the person and/or the IDT. PBS emphasizes the acquisition and maintenance of positive skills (e.g. building healthy relationships) to increase the person's quality of life understanding that a natural reduction in other challenging behaviors will follow. At times, aversive interventions may be temporarily included as a part of a person's behavioral support (usually in the BCIP), and therefore, need to be reviewed prior to implementation as well as periodically while the restrictive intervention is in place. PBSPs not containing aversive interventions do not require HRC review or approval. Plans (e.g., ISPs, PBSPs, BCIPs PPMPs, and/or RMPs) that contain any aversive interventions are submitted to the HRC in advance of a meeting, except in emergency situations. **3.3.4 Interventions Requiring HRC Review and Approval:** HRCs must review prior to implementation, any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies, including but not limited to: 1. response cost; 2. restitution; 3. emergency physical restraint (EPR); 4. routine use of law enforcement as part of a BCIP; 5. routine use of emergency hospitalization procedures as part of a BCIP; 6. use of point systems; 7. use of intense, highly structured, and specialized treatment strategies, including level systems with response cost or failure to earn components; 8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons; 9. use of PRN psychotropic medications;			

10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand); 11. use of bed rails; 12. use of a device and/or monitoring system through PST may impact the person's privacy or other rights; or 13. use of any alarms to alert staff to a person's whereabouts. **3.4 Emergency Physical Restraint (EPR):** Every person shall be free from the use of restrictive physical crisis intervention measures that are unnecessary. Provider Agencies who support people who may occasionally need intervention such as Emergency Physical Restraint (EPR) are required to institute procedures to maximize safety. ***3.4.5 Human Rights Committee:*** The HRC reviews use of EPR. The BCIP may not be implemented without HRC review and approval whenever EPR or other restrictive measure(s) are included. Provider Agencies with an HRC are required to ensure that the HRCs: 1. participate in training regarding required constitution and oversight activities for HRCs; 2. review any BCIP, that include the use of EPR; 3. occur at least annually, occur in any quarter where EPR is used, and occur whenever any change to the BCIP is considered; 4. maintain HRC minutes approving or disallowing the use of EPR as written in a BCIP; and 5. maintain HRC minutes of meetings reviewing the implementation of the BCIP when EPR is used.			

Tag # 1A39 Assistive Technology and Adaptive Equipment	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: 9. supports environmental modifications and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; **10.3.7 Scope of Living Supports (Supported Living, Family Living, and IMLS):** The scope of all Living Supports (Supported Living, Family Living and IMLS) includes, but is not limited to the following as identified by the IDT and ISP: 7. ensuring readily available access to and assistance with use of a person's adaptive equipment, augmentative communication, and assistive technology (AT) devices, including monitoring and support related to maintenance of such equipment and devices to ensure they are in working order; **Chapter 12: Professional and Clinical Services Therapy Services *12.4.1 Participatory Approach:*** The "Participatory Approach" is person-centered and asserts that no one is too severely disabled to benefit from assistive technology and other therapy supports that promote participation in life activities. The Participatory Approach rejects the premise that	Based on record review, observation and interview the Agency did not ensure the necessary support mechanisms and devices, including the rationale for the use of assistive technology or adaptive equipment is in place for 1 of 8 Individuals. **During observation of the Individuals environment no evidence of item was found:** • Hearing Aid (#9) **When DSP were asked for the AT item, the following was reported:** • DSP #586 stated, "He was transferred from Gallup and nothing was sent with him two months ago" (Individual #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?)*: →	

an individual shall be "ready" or demonstrate certain skills before assistive technology can be provided to support function. All therapists are required to consider the Participatory Approach during assessment, treatment planning, and treatment implementation. **12.4.7.3 Assistive Technology (AT) Services, Personal Support Technology (PST) and Environmental Modifications:** Therapists support the person to access and utilize AT, PST and Environmental Modifications through the following requirements: 1. Therapists are required to be or become familiar with AT and PST related to that therapist's practice area and used or needed by individuals on that therapist's caseload. 2. Therapist are required to maintain a current AT Inventory in each Living Supports and CCS site where AT is used, for each person using AT related to that therapist's scope of service. 3. Therapists are required to initiate or update the AT Inventory annually, by the 190th day following the person's ISP effective date, so that it accurately identifies the assistive technology currently in use by the individual and related to that therapist's scope of service. 4. Therapist are required to maintain professional documentation related to the delivery of services related to AT, PST and Environmental Modifications. (Refer to Chapter 14: Other Services for more information about these services.) 5. Therapists must respond to requests to perform in-home evaluations and make recommendations for environmental modifications, as appropriate. 6. Refer to the Publications section on the CSB page on the DOH web site (https://nmhealth.org/about/ddsd/pgsv/clinical/) for Therapy Technical Assistance documents.			

Chapter 11: Community Inclusion **11.6.2 General Service Requirements for CCS Individual, Small Group and Group:** CCS shall be provided based on the interests of the person and Desired Outcomes listed in the ISP. Requirements include: 1. Conducting community-based situational assessments, discovery activities or other person-centered assessments. The assessment will be used to guide the IDT's planning for overcoming barriers to employment and integrating clinical information, assistive technology and therapy supports as necessary for the person to be successful in employment. **11.7.2.2 Job Development:** Job development services through the DD Waiver can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16) and (17) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). 9. Facilitating/developing job accommodations and use of assistive technology such as communication devices.			

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: 1. has basic utilities, i.e., gas, power, water, and telephone; 2. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher; 3. has a general-purpose first aid kit; 4. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift; 5. has water temperature that does not exceed a safe temperature (110^0 F); 6. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP; 7. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy; 8. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 9. supports environmental modifications and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 10 of 13 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:** • Water temperature in home does not exceed safe temperature (120^0 F) • Water temperature in home measured 130.9^0 F (#1, 11) • Emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#5, 9) • Emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy (#2, 3, 4, 12, 13) *Note: The following Individuals share a residence:* ➢ #1, 11 ➢ #5, 9 ➢ #6, 7 **Family Living Requirements:** • Poison Control Phone Number (#14)	**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?)*: →	

individual in consultation with the IDT; 10. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed; 11. has the phone number for poison control within line of site of the telephone; 12. has general household appliances, and kitchen and dining utensils; 13. has proper food storage and cleaning supplies; 14. has adequate food for three meals a day and individual preferences; and 15. has at least two bathrooms for residences with more than two residents.			

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: 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	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 3 of 14 individuals. Individual #1 July 2019 • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) from 7/1 – 3, 2019. Documentation did not contain the required elements on 7/1 – 3, 2019. Documentation received accounted for 0 units. Notes indicated the individual was either on a leave of absence and / or the individual was in the home. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/4/2019. Documentation received accounted for 16 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/5/2019. Documentation received accounted for 8 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/8/2019. Documentation received accounted for 12 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/9/2019. Documentation received accounted for 12 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: a. treatment or care of any eligible recipient; b. services or goods provided to any eligible recipient; c. amounts paid by MAD on behalf of any eligible recipient; and d. any records required by MAD for the administration of Medicaid. **21.9 Billable Units:** The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: 1. A day is considered 24 hours from midnight to midnight. 2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period. 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. 4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows: a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%). b. The receiving Provider Agency bills the	• The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/10/2019. Documentation received accounted for 12 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/11/2019. Documentation received accounted for 12 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/12/2019. Documentation received accounted for 12 units. • The Agency billed 56 units of Customized Community Supports (Individual) (H2021 HB TG) from 7/15 - 16, 2019. Documentation received accounted for 0 units. Notes indicated the individual was either on a leave of absence and / or the individual was in the home. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/17/2019. Documentation received accounted for 12 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/18/2019. Documentation received accounted for 4 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/19/2019. Documentation received accounted for 4 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021		

remaining days up to 340 for the ISP year. **21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days. 2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. 4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit. **21.9.3 Requirements for 15-minute and hourly units**: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following: 1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2. 2. Services that last in their entirety less than eight minutes cannot be billed.	HB TG) on 7/22/2019. Documentation received accounted for 4 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/23/2019. Documentation received accounted for 8 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 07/24/2019. Documentation did not contain the required elements on 07/24/2019. Documentation received accounted for 0 units. Notes indicated the individual was either on a leave of absence and / or the individual was in the home. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/25/2019. Documentation received accounted for 4 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/26/2019. Documentation received accounted for 12 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/30/2019. Documentation received accounted for 8 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 7/31/2019. Documentation received accounted for 8 units. August 2019 • The Agency billed 28 units of Customized Community Supports (Individual) (H2021		

	HB TG) on 8/1/2019. Documentation received accounted for 12 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/2/2019. Documentation received accounted for 12 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/5/2019. Documentation received accounted for 8 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/6/2019. Documentation received accounted for 16 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/7/2019. Documentation received accounted for 16 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/8/2019. Documentation did not contain the required elements on 8/8/2019. Documentation received accounted for 0 units. Notes indicated the individual was either on a leave of absence and / or the individual was in the home. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/9/2019. Documentation received accounted for 20 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/12/2019. Documentation did not contain the required elements on		

	8/12/2019. Documentation received accounted for 0 units. Notes indicated the individual was either on a leave of absence and / or the individual was in the home. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/13/2019. Documentation received accounted for 20 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/14/2019. Documentation received accounted for 20 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/15/2019. Documentation received accounted for 24 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/16/2019. Documentation did not contain the required elements on 8/16/2019. Documentation received accounted for 0 units. Notes indicated the individual was either on a leave of absence and / or the individual was in the home. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/19/2019. Documentation did not contain the required elements on 8/19/2019. Documentation received accounted for 0 units. Notes indicated the individual was either on a leave of absence and / or the individual was in the home. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/20/2019. Documentation did		

	not contain the required elements on 8/20/2019. Documentation received accounted for 0 units. Notes indicated the individual was either on a leave of absence and / or the individual was in the home. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/26/2019. Documentation received accounted for 24 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/29/2019. Documentation received accounted for 20 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 8/30/2019. Documentation received accounted for 16 units. September 2019 • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/2/2019. Documentation received accounted for 12 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/3/2019. Documentation received accounted for 16 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/5/2019. Documentation did not contain the required elements on 9/5/2019. Documentation received accounted for 0 units. Notes indicated the individual was either on a leave of absence and / or the individual was in the home.		

	• The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/10/2019. Documentation received accounted for 16 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/12/2019. Documentation received accounted for 12 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/13/2019. Documentation received accounted for 16 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/16/2019. Documentation received accounted for 8 units. • The Agency billed 24 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/17/2019. Documentation received accounted for 12 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/18/2019. Documentation received accounted for 16 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/19/2019. Documentation received accounted for 20 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/20/2019. Documentation received accounted for 16 units.		

	• The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/24/2019. Documentation received accounted for 20 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/25/2019. Documentation received accounted for 20 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/26/2019. Documentation received accounted for 16 units. • The Agency billed 28 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/27/2019. Documentation received accounted for 20 units. • The Agency billed 24 units of Customized Community Supports (Individual) (H2021 HB TG) on 9/30/2019. Documentation received accounted for 16 units. Individual #5 September 2019 • The Agency billed 52 units of Customized Community Supports (Individual) (H2021 HB U1) on 9/20/2019. Documentation received accounted for 20 units. Individual #15 August 2019 • The Agency billed 28 units of Customized Community Supports (Group) (T2021 HB U9) on 8/28/2019. Documentation received accounted for 1 unit.		

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;	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 12 individuals. Individual #1 July 2019 • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 7/11/2019. 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 5 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 7/20/2019. 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 4 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) 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 U7) on 7/22/2019.	**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?)*: →	

b. services or goods provided to any eligible recipient; c. amounts paid by MAD on behalf of any eligible recipient; and d. any records required by MAD for the administration of Medicaid. **21.9 Billable Units:** The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: 1. A day is considered 24 hours from midnight to midnight. 2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period. 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. 4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows: a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%). b. The receiving Provider Agency bills the remaining days up to 340 for the ISP year.	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 10 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 7/29/2019. 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 U7) on 7/30/2019. 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 5 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 7/31/2019. 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 5 hours, which is less than the required amount. August 2019 • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 8/9/2019. Documentation		

21.9.2 Requirements for Monthly Units: For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days. 2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. 4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit. **21.9.3 Requirements for 15-minute and hourly units**: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following: 1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2. 2. Services that last in their entirety less than eight minutes cannot be billed.	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 10 hours, which is less than the required amount. • The Agency billed 2 units of Supported Living (T2016 HB U7) from 8/10 – 11, 2019. Documentation did not contain the required elements from 8/10 – 11, 2019. Documentation received accounted for 0 units. Note indicated the Individual was on a leave of absence. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 8/13/2019. 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 10 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 8/14/2019. 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 2 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 8/15/2019. 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 1 hour, which is less than the required amount. • The Agency billed 4 units of Supported Living (T2016 HB U7) from 8/16 – 19, 2019. Documentation did not contain the required elements from 8/16 – 19, 2019. Documentation received accounted for 0 units. Notes indicated the Individual was on a leave of absence. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 8/21/2019. 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 4 units of Supported Living (T2016 HB U7) from 8/22 – 25, 2019. Documentation did not contain the required elements from 8/22 – 25, 2019. Documentation received accounted for 0 units. Note indicated the Individual was on a leave of absence. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 8/26/2019. 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 1 hour, which is less than the required amount • The Agency billed 2 units of Supported Living (T2016 HB U7) from 8/27 – 28, 2019.		

	Documentation did not contain the required elements from 8/27 – 28, 2019. Documentation received accounted for 0 units. Notes indicated the Individual was on a leave of absence. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 8/29/2019. 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 10 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 8/30/2019. 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 7 hours, which is less than the required amount. September 2019 • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/2/2019. 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 4 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/3/2019. 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 3 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/4/2019. 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 4 hours, which is less than the required amount. • The Agency billed 5 units of Supported Living (T2016 HB U7) from 9/5 - 9, 2019. Documentation did not contain the required elements from 9/5 - 9, 2019. Documentation received accounted for 0 units. Notes indicated the Individual was on a leave of absence. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/10/2019. 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 3 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) from 9/11/2019. Documentation did not contain the required elements from 9/11/2019. Documentation received accounted for 0 units. Note indicated the Individual was on a leave of absence. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/12/2019.		

	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 4 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/17/2019. 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 4 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/18/2019. 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 3 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/19/2019. 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 2 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/20/2019. 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 11 hours, which is less than the required amount. • The Agency billed 3 units of Supported Living (T2016 HB U7) from 9/21 - 23, 2019. Documentation did not contain the required elements from 9/21- 23, 2019. Documentation received accounted for 0 units. Notes indicated the Individual was on a leave of absence. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/24/2019. 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 2 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/25/2019. 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 1 hour, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/26/2019. 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 3 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/30/2019. 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 10 hours, which is less than the required amount. Individual #2 July 2019 • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/2/2019. 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 4 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/18/2019. 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 9 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/23/2019. 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 4 hours, which is less than the required amount. Individual #6 August 2019 • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/15/2019. 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 11 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/30/2019. 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 10 hours, which is less than the required amount. September 2019 • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 9/3/2019. 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 10 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 9/19/2019. 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 4 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 9/26/2019. 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 11 hours, which is less than the required amount. Individual #7 July 2019 • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 7/29/2019. 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 11 hours, which is less than the required amount. August 2019 • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 8/19/2019. 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 9 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 8/29/2019. 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. September 2019 • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/23/2019. 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 10 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/24/2019. 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 11 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 9/26/2019. 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 4 hours, which is less than the required amount. Individual #13 July 2019		

	• The Agency billed 1 unit of Supported Living (T2016 HB U6) on 7/19/2019. 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 11 hours, which is less than the required amount. August 2019 • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 8/16/2019. 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 U6) on 8/21/2019. 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 8.5 hours, which is less than the required amount. September 2019 • The Agency billed 1 unit of Supported Living (T2016 HB U6) on 9/14/2019. 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 11 hours, which is less than the required amount.		

Date: February 18, 2020

To: Scott Good, State Director
Provider: Dungarvin New Mexico, LLC
Address: 2309 Renard Place SE, Suite 205
State/Zip: Albuquerque, New Mexico 87106

E-mail Address: scgood@dungarvin.com
clopezbeck@dungarvin.com
kmarshall@dungarvin.com
bmyers@dungarvin.com

Region: Metro & Northwest (Grants)
Survey Date: November 1 – 7, 2019

Program Surveyed: Developmental Disabilities Waiver

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

Survey Type: Routine

Dear Mr. Good and Mrs. Lopez-Beck:

The Division of Health Improvement Quality Management Bureau received and reviewed the documents you submitted for your Plan of Correction. Your Plan of Correction is not closed.

Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.

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

If the Verification survey determines survey deficiencies have been corrected and corrective measures have effectively maintained compliance with DDW Standards, your Plan of Correction will be considered for closure.

If the Verification survey identifies repeat deficiencies, the Plan of Correction process will continue and your case may be referred to the Internal Review Committee for discussion of possible 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, BS
Healthcare Surveyor Advanced/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.20.2.DDW.D1696.1,5.RTN.07.19.049