MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO
DEPARTMENT OF
HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date: November 26, 2019

To: Mrs. Chitra Roy, President and Owner
Provider: Optihealth, Inc.
Address: 4620 Jefferson Lane NE
City, State, Zip: Albuquerque, New Mexico 87109

E-mail Address: croy@optihealthnm.com

Region: Metro
Routine Survey: March 1 - 6, 2019
Verification Survey: October 25 - 30, 2019

Program Surveyed: Developmental Disabilities Waiver

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

Survey Type: Verification

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

Team Member: Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau

Dear Ms. Chitra Roy;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on March 1 – 6, 2019*.

The Division of Health Improvement, Quality Management Bureau has determined your agency is now 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 **(New / Repeat Findings)**
- Tag # LS14 Residential Case File (ISP and Healthcare Requirements) **(Repeat Findings)**
- Tag # 1A22 Agency Personnel Competency **(Repeat Findings)**
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up **(New / Repeat Findings)**
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans) **(Repeat Findings)**
- Tag # 1A31 Client rights/Human Rights **(Repeat Findings)**

The following tags are identified as Standard Level:

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

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

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

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

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

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

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

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

Please call the Plan of Correction Coordinator Monica Valdez at 505-273-1930 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Yolanda J. Herrera, RN

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

Survey Process Employed:

Administrative Review Start Date:	October 25, 2019
Contact:	**Optihealth, Inc.** Chitra Roy, President and Owner **DOH/DHI/QMB** Yolanda J. Herrera, RN, Team Lead/Nurse Healthcare Surveyor
On-site Entrance Conference Date:	October 28, 2019
Present:	**Optihealth, Inc.** Chitra Roy, President and Owner Joey Dominguez, House Manager Brian Williams, Service Coordinator Pam Wilson, Nursing Administration Assistant Brenda Allen, Service Coordinator Melissa Bond, Director of Operations **DOH/DHI/QMB** Yolanda J. Herrera, RN, Team Lead/Nurse Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator
Exit Conference Date:	October 30, 2019
Present:	**Optihealth, Inc.** Joe Pacheco, QA/QI Manager / Trainer Brenda Allen, Service Coordinator Pam Wilson, Nursing Administration Assistant **DOH/DHI/QMB** Yolanda J. Herrera, RN, Team Lead/Nurse Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator **DDSD – Metro Regional Office** Marie Velasco, Social Community Service Coordinator
Administrative Locations Visited	1
Total Sample Size	6 0 - *Jackson* Class Members 6 - Non-*Jackson* Class Members 5 - Supported Living 1 - Customized In-Home Supports 4 - Customized Community Supports
Persons Served Records Reviewed	6
Direct Support Personnel Interviewed during Routine Survey	8
Direct Support Personnel Records Reviewed	51 *(One Service Coordinator performs dual roles as a DSP)*

Service Coordinator Records Reviewed 3 *(One Service Coordinator performs dual roles as a DSP)*

Administrative Interviews completed during Routine Survey 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
IRC – Internal Review Committee

Attachment B

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

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

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

Service Domains and CoPs for <u>Living Care Arrangements and Community Inclusion</u> are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attachment C

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

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

Instructions:

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

The following limitations apply to the IRF process:

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

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

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

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

Attachment D

QMB Determinations of Compliance

Compliance:

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

Partial-Compliance with Standard Level Tags:

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

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

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

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

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

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

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

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

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

Agency: **Optihealth, Inc. – Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Supported Living, Customized In-Home Supports, Customized Community Supports
Survey Type: Verification
Routine Survey: **March 1 - 6, 2019**
Verification Survey: **October 25 - 30, 2019**

Standard of Care	Routine Survey Deficiencies March 1 – 6, 2019	Verification Survey New and Repeat Deficiencies October 25 – 30, 2019
Service Domain: Service Plans: ISP Implementation - *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	**Condition of Participation Level Deficiency**	**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,	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 1 of 6 individuals. **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #4 • None found regarding: Live Outcome/Action Step: "... will identify what items need to be in his bag" for 11/2018 - 12/2018. Action step is to be completed 1 time per month as needed. • None found regarding: Live Outcome/Action Step: "... will purchase items for his hygiene bag" for 11/2018 - 12/2018. Action step is to be completed 1 time per month as needed. • None found regarding: Live Outcome/Action Step: "... will use the items in his bag" for 11/2018 -	**New / Repeat Finding:** 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 1 of 6 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #4 • None found regarding: Work/Learn Outcome; Action Step: "... will track his weight loss" for 8/2019 – 9/2019. Action step is to be completed 1 time per month.

education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; 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	12/2018. Action step is to be completed 1 time per day. • None found regarding: Fun Outcome/Action Step: "... will identify two places he would like to travel to" for 11/2018 - 12/2018. Action step is to be completed 1 time per month or as needed until he selects a location. • None found regarding: Fun Outcome/Action Step: "... will identify activities he would like participate in while there" for 11/2018 - 12/2018. Action step is to be completed 1 time per month. • None found regarding: Fun Outcome/Action Step: "Budget and save money for trip" for 11/2018 - 12/2018. Action step is to be completed 1 time per month or as needed.	

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

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)	Standard Level Deficiency	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 play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental	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 6 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #2 • According to the Live Outcome; Action Step for "With staff support ... will choose information he would like to access" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2018 - 1/2019. • According to the Health/Other Outcome; Action Step for "... will be weighted weekly" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2018 - 12/2018. • According to the Health/Other Outcome; Action Step for "... and staff will follow nutritional plan" 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 11/2018 - 1/2019. • According to the Health/Other Outcome; Action Step for "... will complete physical activity" is to be	**New / Repeat Findings:** Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 3 of 6 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #2 • According to the Live Outcome; Action Step for "With staff support ... will choose information he would like to access" 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 9/2019. • According to the Health/Other Outcome; Action Step for "... will be weighed weekly" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2019 - 9/2019. • According to the Health/Other Outcome; Action Step for "... and staff will follow nutritional plan" 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 8/2019 - 9/2019.

disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 6: Individual Service Plan (ISP)** **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person	completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2018 - 1/2019. Individual #4 • According to the Live Outcome; Action Step for "... will use the items in his bag" 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 1/2019. • According to the Fun Outcome; Action Step for "He will identify expenses associated with the trip" is to be completed 2 times per month as needed. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2019. Individual #6 • According to the Fun Outcome; Action Step for "... will budget for a trip" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2018 - 1/2019. **Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • According to the Live Outcome; Action Step for "... will do two doctor appointments a month" 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 11/2018.	• According to the Health/Other Outcome; Action Step for "... will complete physical activity" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2019 - 9/2019. Individual #4 • According to the Live Outcome; Action Step for "... will use the items in his bag" 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 8/2019 - 9/2019. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #2 • According to the Work/Learn, Outcome; Action Step for "... will play a game that requires physical movement" is to be completed 6 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2019. Individual #3 • According to the Fun Outcome; Action Step for "... will choose a physical activity" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2019 - 9/2019. • According to the Fun Outcome; Action Step for "... will participate in a physical activity" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2019 - 9/2019. Individual #4

during the provision of the service. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.	**Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #2 • According to the Work/Learn, Outcome; Action Step for "... will spend time in nature 6x a month." Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2018 - 1/2019. Individual #3 • According to the Fun Outcome; Action Step for "... will choose a physical activity" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2018 - 12/2018. • According to the Fun Outcome; Action Step for "... will participate in a physical activity" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2018 - 12/2018. Individual #4 • According to the Work/Learn Outcome; Action Step for "... will participate in the physical activity" is to be completed 1-3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2019. • According to the Work/Learn Outcome; Action Step for "... will track his weight loss" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2019.	• According to the Work/Learn Outcome; Action Step for "... will choose a physical activity of his choice to participate in out in the community" is to be completed 1 - 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2019. • According to the Work/Learn Outcome; Action Step for "... will participate in the physical activity" is to be completed 1 - 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2019.

Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements *(Upheld by IRF during RTN survey)*	Standard Level Deficiency	Standard Level Deficiency
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. Provider Agencies must have readily accessible records in home and community settings in paper or	Based on record review, the Agency did not complete written status reports as required for 6 of 6 individuals receiving Living Care Arrangements and Community Inclusion. **Supported Living Semi-Annual Reports:** • Individual #2 - None found for 9/2017 - 3/2018 (Term of ISP 9/24/2017 - 9/23/2018); Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 3/2018 - 5/2018; Date Completed: 7/25/2018; ISP meeting held on 6/5/2018). • Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 4/2018 - 6/2018; Date Completed: 8/20/2018; ISP meeting held on 7/10/2018). • Individual #5 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 12/2017 - 2/2018; Date Completed: 6/20/2018; ISP meeting held on 3/6/2018). • Individual #6 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 1/11/2018 - 1/12/2019; Date Completed: 1/31/2019; ISP meeting held on 10/12/2018). **Customized In-Home Supports Semi-Annual Reports:** • Individual #1 - None found for 2/2018 - 5/2018. (Term of ISP 8/10/2018 - 8/9/2019. ISP meeting held on 5/18/2018). *Note: Finding for Individual #1, CIHS Semi-Annual, upheld by IRF 6/18/2019.* **Customized Community Supports Semi-Annual Reports:**	**New / Repeat Findings:** Based on record review, the Agency did not complete written status reports as required for 5 of 6 individuals receiving Living Care Arrangements and Community Inclusion. **Supported Living Semi-Annual Reports:** • Individual #3 - None found for 10/2018 - 4/2019 and 4/2019 - 7/2019. *(Term of ISP 10/20/2018 - 10/19/2019. ISP meeting held on 7/25/2019).* • Individual #5 - None found for 12/2018 - 2/2019. *(Term of ISP 6/2/2018 - 6/1/2019. ISP meeting held on 3/8/2019).* **Customized In-Home Supports Semi-Annual Reports:** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Semi-Annual Report 8/10/2018 - 8/10/2019; Date Completed: 6/14/2019; ISP meeting held on 5/7/2019).* **Customized Community Supports Semi-Annual Reports:** • Individual #2 - None found for 3/2019 - 6/2019. *(Term of ISP 9/24/2018 - 9/23/2019. ISP meeting held on 6/24/2019).* • Individual #3 - None found for 10/2018 - 4/2019 and 4/2019 - 7/2019. *(Term of ISP 10/20/2018 - 10/19/2019. ISP meeting held on 7/25/2019).* • Individual #4 – None found for 1/2019. Report covered 2/4/2019 – 7/4/2019. *(Term of ISP 1/5/2019 - 1/4/2020).. (Per regulations reports must coincide with ISP term)*

electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **Chapter 19: Provider Reporting Requirements 19.5 Semi-Annual Reporting:** The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDSD for QA activities. Semi-annual reports are required as follows: DD Waiver Provider Agencies, except AT, EMSP, Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports. 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	• Individual #2- Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 3/2018 - 5/2018; Date Completed: 7/25/2018; ISP meeting held on 6/5/2018). • Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 4/2018 - 6/2018; Date Completed: 7/22/2018; ISP meeting held on 7/10/2018). • Individual #4 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 1/2018 - 1/2019; Date Completed: 10/17/2018; ISP meeting held on 10/17/2018). • Individual #6 - None found for 7/2018 - 10/2018. (Term of ISP 1/12/2018 - 1/11/2019. ISP meeting held on 10/22/2018). **Nursing Semi-Annual / Quarterly Reports:** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 3/2018 - 8/2018; Date Completed: 9/3/2018; ISP meeting held on 5/18/2018). • Individual #2 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 3/2018 - 5/2018; Date Completed: 12/1/2018; ISP meeting held on 6/5/2018). • Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 4/23/2018 - 10/24/2018; Date Completed: 12/1/2018; ISP meeting held on 7/10/2018). • Individual #4 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 7/7/2018 - 1/6/2019; Date Completed: 2/9/2019; ISP meeting held on 10/17/2018).	

Respite is the only service included in the ISP other than Case Management, for an adult age 21 or older. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days). The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting. Semi-annual reports must contain at a minimum written documentation of: 1. the name of the person and date on each page; 2. the timeframe that the report covers; 3. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering; 4. a description of progress towards Desired Outcomes in the ISP related to the service provided; 5. a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing); 6. significant changes in routine or staffing if applicable; 7. unusual or significant life events, including significant change of health or behavioral health condition; 8. the signature of the agency staff responsible for preparing the report; and 9. any other required elements by service type that are detailed in these standards.	• Individual #6 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 7/13/2018 - 1/11/2019; Date Completed: 1/18/2019; ISP meeting held on 10/12/2018).	

Tag # LS14 Residential Case File (ISP and Healthcare Requirements)	Condition of Participation Level Deficiency	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: Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their	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 5 of 6 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Teaching and Support Strategies:** ***Individual #3:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "... will review chore list with staff." **Individual #4:** *TSS not found for the following Live Outcome Statement / Action Steps:* • "... will identify what items need to be in his bag." • "... will purchase items for his hygiene bag." • *TSS not found for the following Fun Outcome Statement / Action Steps:* • "... will identify two places he would like to travel to." • "He will identify expenses associated with the trip." • "Budget and save money for trip."	**Repeat Finding:** 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 1 of 6 Individuals receiving Living Care Arrangements. Review of Therap revealed the following items were not found, incomplete, and/or not current: **Medical Emergency Response Plans:** • Gastrointestinal (#3)

agency. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. Requirements for the *Health Passport* and *Physician Consultation* form are: 2. The Primary and Secondary Provider Agencies must ensure that a current copy of the *Health Passport* and *Physician Consultation* forms are printed and available at all service delivery sites. Both forms must be reprinted and placed at all service delivery sites each time the e-CHAT is updated for any reason and whenever there is a change to contact information contained in the IDF. **Chapter 13: Nursing Services: 13.2.9 Healthcare Plans (HCP)*:*** At the nurse's discretion, based on prudent nursing	**Individual #5:** *TSS not found for the following Live Outcome Statement / Action Steps:* • "... will choose the dish she wants to make." • "... will practice preparing the dish." *TSS not found for the following Fun Outcome Statement / Action Steps:* • "... will choose the date, theme and menu for her party." • "... will make her guest list and invitations." • "... will prepare for her party." **Individual #6:** *TSS not found for the following Live Outcome Statement / Action Steps:* • "... will prepare a simple meal, with assistance." *TSS not found for the following Fun Outcome Statement / Action Steps:* • "... will plan a day or overnight trip and take a trip." • "... will budget for the trip." **Health Care Plans:** • Anaphylactic Reaction (#2) • Falls (#3) **Medical Emergency Response Plans:** • Antipsychotic and Extrapyramidal Symptoms (#3) • Falls (#3) • Gastrointestinal (#3)	

practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary **13.2.10 *Medical Emergency Response Plan (MERP):*** • 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. • MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.	• Seizures (#3)	

Standard of Care	Routine Survey Deficiencies March 1 – 6, 2019	Verification Survey New and Repeat Deficiencies October 25 – 30, 2019
Service Domain: Qualified Providers - *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A22 Agency Personnel Competency	**Condition of Participation Level Deficiency**	**Condition of Participation Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 13: Nursing Services *13.2.11 Training and Implementation of Plans:*** RNs and LPNs are required to provide Individual Specific Training (IST) regarding HCPs and MERPs. The agency nurse is required to deliver and document training for DSP/DSS regarding the healthcare interventions/strategies and MERPs that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee as described in Chapter 17.10 Individual-Specific Training. **Chapter 17: Training Requirement** **17.10 Individual-Specific Training:** The following are elements of IST: defined standards of performance, curriculum tailored to teach 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 5 of 9 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 the plan covered, the following was reported:** • DSP #500 stated, "I have no clue." According to the Individual Specific Training Requirements section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #4) **When DSP were asked if they received training on the Individual's Behavioral Crisis Intervention Plan (BCIP) and if so, what the plan covered, the following was reported:** • DSP #510 stated, "Yes...well-being - safety." According to the Individual Specific Training Requirements section of the ISP, the individual does not have a Behavioral Crisis Intervention Plan. (Individual #2) **When DSP were asked if they received training on the Individual's Speech Therapy Plan and if so, what the plan covered, the following was reported:**	**Repeat Finding:** 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 ensure training competencies were met for 3 of 9 Direct Support Personnel. • The Agency did not provide verification that staff had been trained / retrained in the areas they were cited during the routine survey (DSP #500, 516, 532).

Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends. IST for therapy-related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher. The competency level of the training is based on the IST section of the ISP. The person should be present for and involved in IST whenever possible. Provider Agencies are responsible for tracking of IST requirements. Provider Agencies must arrange and ensure that DSP's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans	• DSP #500 stated, "No, I'm just getting trained on some things." According to the Individual Specific Training Requirements section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #4) • DSP #509 stated, "I'm not aware if she does. I have never meet her SLP if she does." According to the Individual Specific Training Requirements section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #5) **When DSP were asked if they received training on the Individual's Occupational Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #509 stated, "I don't know if she does." According to the Individual Specific Training Requirements section of the ISP, the Individual does not require an Occupational Therapy Plan. (Individual #5) **When DSP were asked if the Individual required a physical restraint such as MANDT, CPI or Handle with care, the following was reported:** • DSP #500 stated, "Yes." The individual does not require any physical restraints per the Positive Behavioral Support Plan. (Individual #4) **When DSP were asked if the Individual had a Comprehensive Aspiration Risk Management Plan (CARMP) and where it was located, the following was reported:** • DSP #532 stated, "No." As indicated by the Aspiration Risk Screening Tool on 9/3/2018 he is at moderate risk for aspiration which would require a CARMP. (Individual #1)	

section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan.	**When DSP were asked if the Individual had a Medical Emergency Response Plan for Seizure, the following was reported:** • DSP #545 stated, "No, not that I know of no plan for seizures." As indicated by the Individual Specific Training section of the ISP the Individual requires a Medical Emergency Response Plan for Seizures. (Individual #3) **When DSP were asked to give examples of Abuse, Neglect and Exploitation, the following was reported, with regards to Exploitation:** • DSP #516 stated "Telling people about him that they shouldn't know." (Individual #4)	

Standard of Care	Routine Survey Deficiencies March 1 – 6, 2019	Verification Survey New and Repeat Deficiencies October 25 – 30, 2019
Service Domain: Health and Welfare - *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Condition of Participation Level Deficiency**	**Condition of Participation Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 3 Safeguards: 3.1.1 *Decision Consultation Process (DCP):*** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: 1. 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; 2. 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; 3. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and 4. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 3 of 6 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 #6 - As indicated by collateral documentation reviewed, exam was completed on 2/27/2018. Follow-up was to be completed in 1 year. No evidence of follow-up found. **Vision Exam:** • Individual #6 - As indicated by collateral documentation reviewed, exam was completed on 1/15/2018. Follow-up was to be completed in 1 year. No evidence of follow-up found. **Blood Levels:** • Individual #6 - As indicated by collateral documentation reviewed, lab work was ordered on 7/11/2018. No evidence of lab results was found.	**New / Repeat Finding:** After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 1 of 6 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):*** **Podiatry Exam:** • Individual #1 - As indicated by collateral documentation reviewed, exam was completed on 3/5/2018. Follow-up was to be completed in 3 months. No evidence of follow-up found. *(Note: Follow-up scheduled for 6/6/2019, Individual declined appointment. Follow-up appointments were rescheduled for 6/17/2019 and 7/22/2019, which were declined by the Individual). No evidence found indicating how the Agency is addressing the Individual declining the appointments.*

2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: 1. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. **2.** The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records	**Neurology Exam:** • Individual #6 - As indicated by collateral documentation reviewed, exam was completed in 11/2017. Follow-up was to be completed in 1 year. No evidence of follow-up found. **Podiatry Exam:** • Individual #1 - As indicated by collateral documentation reviewed, exam was completed on 3/5/2018. Follow-up was to be completed in 3 months. No evidence of follow-up found. • Individual #2 - As indicated by collateral documentation reviewed, exam was completed on 7/12/2018. Follow-up was to be completed in 3 months. No evidence of follow-up found.	

through the Therap web based system using computers or mobile devices is acceptable. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5.3 *Health Passport and Physician Consultation Form:*** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications.		

Chapter 10: Living Care Arrangements (LCA) Living Supports-Supported Living: 10.3.9.6.1 Monitoring and Supervision 4. Ensure and document the following: 1. The person has a Primary Care Practitioner. 2. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist. 3. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist. 4. The person receives a hearing test as recommended by a licensed audiologist. 5. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist. 5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine). **10.3.10.1 Living Care Arrangements (LCA) Living Supports-IMLS: 10.3.10.2 General Requirements:** 9 . Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and annual dental checkup by a licensed dentist). **Chapter 13 Nursing Services: 13.2.3 General Requirements:** Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information.		

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Condition of Participation Level Deficiency	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: Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. The current Client File Matrix found in Appendix A	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 6 individual Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Healthcare Passport:** • Did not contain Guardianship Information (#4) • Did not contain Emergency contact (#4) **Health Care Plans (HCP):** ***Diabetes:*** • Individual #6 - 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 (MERP):** ***Allergies:*** • Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Cardiac Condition:*** • Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Gastrointestinal:***	**Repeat Findings:** 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 2 of 6 individual Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Medical Emergency Response Plans (MERP):** ***Allergies:*** • Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Cardiac Condition:*** • Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Gastrointestinal:*** • Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.

Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **Chapter 3 Safeguards: 3.1.1 *Decision Consultation Process (DCP):*** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: 1. 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; 2. 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; 3. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and 4. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.	• Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.	

2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: 1. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. **2.** The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting. **Chapter 13 Nursing Services:** ***13.2.5 Electronic Nursing Assessment and Planning Process:*** The nursing assessment process includes several DDSD mandated tools: the electronic Comprehensive Nursing Assessment Tool (e-CHAT), the Aspiration Risk Screening Tool (ARST) and the Medication Administration Assessment Tool (MAAT) . This process includes developing and training Health Care Plans and Medical Emergency Response Plans. The following hierarchy is based on budgeted services and is used to identify which Provider Agency nurse has primary responsibility for completion of the nursing assessment process and related subsequent planning and training. Additional communication and collaboration for planning specific to CCS or CIE services may be needed. The hierarchy for Nursing Assessment and Planning responsibilities is:		

Living Supports: Supported Living, IMLS or Family Living via ANS; Customized Community Supports- Group; and Adult Nursing Services (ANS): 1. for persons in Community Inclusion with health-related needs; or 2. if no residential services are budgeted but assessment is desired and health needs may exist. ***13.2.6 The Electronic Comprehensive Health Assessment Tool (e-CHAT)*** The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person. The nurse must see the person face-to-face to complete the nursing assessment. Additional information may be gathered from members of the IDT and other sources. An e-CHAT is required for persons in FL, SL, IMLS, or CCS-Group. All other DD Waiver recipients may obtain an e-CHAT if needed or desired by adding ANS hours for assessment and consultation to their budget. When completing the e-CHAT, the nurse is required to review and update the electronic record and consider the diagnoses, medications, treatments, and overall status of the person. Discussion with others may be needed to obtain critical information. The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections. ***13.2.7 Aspiration Risk Management Screening Tool (ARST)*** ***13.2.8 Medication Administration Assessment Tool (MAAT):*** A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting. After completion of the MAAT, the nurse will present recommendations regarding the level of assistance		

with medication delivery (AWMD) to the IDT. A copy of the MAAT will be sent to all the team members two weeks before the annual ISP meeting and the original MAAT will be retained in the Provider Agency records. Decisions about medication delivery are made by the IDT to promote a person's 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)*:*** • At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. • In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs plans that the nurse determines are warranted. ***13.2.10 Medical Emergency Response Plan (MERP):*** The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions		

marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation. **Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form.		

Tag # 1A31 Client Rights/Human Rights	Condition of Participation Level Deficiency	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 **Chapter 2: Human Rights:** Civil rights apply to everyone, including all waiver participants, family members, guardians, natural supports, and Provider	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 2 of 6 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. No current Human Rights Approval was found for the following: • Law Enforcement Involvement. Last Review was dated 4/25/2017. (Individual #3) • Physical Restraint (Handle with Care) Last Review was dated 4/25/2017. (Individual #3) • Psychotropic Medications to control behaviors. Last Review was dated 4/25/2017. (Individual #3) • Psychotropic Medications to control behaviors. Last Review was dated 4/25/2017. (Individual #6)	**Repeat Finding:** 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 1 of 6 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. No current Human Rights Approval was found for the following: • Law Enforcement Involvement. Last Review was dated 4/25/2017. (Individual #3)

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:*** 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. 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. The plan's author, designated staff (e.g., agency service coordinator) and/or the CM makes a written or oral presentation to the HRC. 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. HRC committees are required to meet at least on a quarterly basis. 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. 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. 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: • response cost; • restitution; • emergency physical restraint (EPR); • routine use of law enforcement as part of a BCIP; • routine use of emergency hospitalization procedures as part of a BCIP; • use of point systems; • use of intense, highly structured, and specialized treatment strategies, including level systems with response cost or failure to earn components; • 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; • use of PRN psychotropic medications; • use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand); • use of bed rails; • use of a device and/or monitoring system through PST may impact the person's privacy or other rights; or • 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: • participate in training regarding required constitution and oversight activities for HRCs; • review any BCIP, that include the use of EPR; • occur at least annually, occur in any quarter where EPR is used, and occur whenever any change to the BCIP is considered; • maintain HRC minutes approving or disallowing the use of EPR as written in a BCIP; and • maintain HRC minutes of meetings reviewing the implementation of the BCIP when EPR is used.		

Standard of Care	Routine Survey Deficiencies March 1 – 6, 2019	Verification Survey New and Repeat Deficiencies October 25 – 30, 2019
Service Domain: Service Plans: ISP Implementation - *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A08 Administrative Case File (Other Required Documents)	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # IS04 Community Life Engagement	**Standard Level Deficiency**	**COMPLETE**
Tag # IS12 Person Centered Assessment (Inclusion Services)	**Standard Level Deficiency**	**COMPLETE**
Tag # LS14.1 Residential Case File (Other Required Documentation)	**Standard Level Deficiency**	**COMPLETE**
Tag # IS14 CCS / CIES Service Delivery Site - Case File (ISP and Healthcare Requirements)	**Condition of Participation Level Deficiency**	**COMPLETE**
Service Domain: Qualified Providers - *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A20 Direct Support Personnel Training	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A25 Caregiver Criminal History Screening	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A26.1 Consolidated On-line Registry Employee Abuse Registry *(Upheld by IRF during RTN survey)*	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A43.1 General Events Reporting - Individual Reporting	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Health and Welfare - *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A09 Medication Delivery - Routine Medication Administration	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A09.1 Medication Delivery PRN Medication Administration	**Condition of Participation Level Deficiency**	**COMPLETE**

Tag # 1A29 Complaints / Grievances Acknowledgement	**Standard Level Deficiency**	**COMPLETE**
Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	**Standard Level Deficiency**	**COMPLETE**
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 ***(Modified by IRF during RTN survey)***	**Standard Level Deficiency**	**COMPLETE**
Tag # LS26 Supported Living Reimbursement ***(Upheld by IRF during RTN survey)***	**Standard Level Deficiency**	**COMPLETE**

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

Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements ***(Upheld by IRF during RTN survey)***	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # LS14 Residential Case File (ISP and Healthcare Requirements)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A22 Agency Personnel Competency	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # 1A31 Client Rights/Human Rights	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO
DEPARTMENT OF
HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date: May 4, 2020

To: Mrs. Chitra Roy, President and Owner
Provider: Optihealth, Inc.
Address: 4620 Jefferson Lane NE
City, State, Zip: Albuquerque, New Mexico 87109

E-mail Address: croy@optihealthnm.com

Region: Metro
Routine Survey: March 1 - 6, 2019
Verification Survey: October 25 - 30, 2019

Program Surveyed: Developmental Disabilities Waiver

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

Survey Type: Verification

Dear Mrs. Roy:

The Division of Health Improvement Quality Management Bureau received and reviewed the documents you submitted for your Plan of Correction. Due to the Non-Compliance received during the Verification Survey, your Plan of Correction is not closed. **Your Plan of Correction will be considered for closure when a second Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.**

As well as the above, you must continue working with the Internal Review Committee (IRC) to address areas under review by the IRC.

The Quality Management Bureau will need to conduct a second 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.

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

ACCREDITED HEALTH DEPARTMENT • PUBLIC HEALTH ACCREDITATION BOARD • PHAB Advancing public health performance

Sincerely,

Monica Valdez, BS

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

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