NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

| | |
|---|---|
| Date: | April 5, 2022 |
| To: | Bobby LeDoux, Executive Director |
| Provider:<br>Address:<br>State/Zip: | Citizens for the Developmentally Disabled<br>230 4th Avenue<br>Raton, New Mexico 87740 |
| E-mail Address: | Bobby@bacavalley.com |
| Region:<br>Survey Date: | Northeast<br>March 7 - 18, 2022 |
| Program Surveyed: | Developmental Disabilities Waiver |
| Service Surveyed: | Supported Living, Family Living, Customized In-Home Supports, and Customized Community Supports |
| Survey Type: | Routine |
| Team Leader: | Verna Newman-Sikes, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau |
| Team Members: | Bernadette D Baca, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Kayla R. Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Joshua Burghart, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau |

Dear Mr. LeDoux,

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

**Determination of Compliance:**

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

***Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags:*** This determination is based on noncompliance with one to five (1 – 5) Condition of Participation Level Tags *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation
- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)

The following tags are identified as Standard Level:

- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*
- Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)
- Tag # LS25 Residential Health & Safety (Supported Living & Family Living)
- Tag # IS30 Customized Community Supports Reimbursement

**Plan of Correction:**

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

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

**Corrective Action for Current Citation**:

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

**On-going Quality Assurance/Quality Improvement Processes:**

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

**Submission of your Plan of Correction:**

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

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

1. **Quality Management Bureau, Attention: Monica Valdez, Plan of Correction Coordinator in any of the following ways:**
   a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108

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

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

**Billing Deficiencies:**
If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a "Void/Adjust" claim or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: *Lisa Medina-Lujan*
HSD/OIG/Program Integrity Unit
1474 Rodeo Road
Santa Fe, New Mexico 87505

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

*Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)*

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

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

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

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

Please contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@state.nm.us 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,

Verna Newman-Sikes, AA

Verna Newman-Sikes, AA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

**Survey Process Employed:**

| | |
|---|---|
| Administrative Review Start Date: | March 7, 2022 |
| Contact: | **Citizens for the Developmentally Disabled**<br>Bobby LeDoux, Executive Director<br><br>**DOH/DHI/QMB**<br>Bernadette D. Baca, MPA, Healthcare Surveyor |
| On-site Entrance Conference Date: | March 7, 2022 |
| Present: | **Citizens for the Developmentally Disabled**<br>Cassandra Gonzales, Site Director/Service Coordinator<br>Anita Lopez, Director of Nursing / RN<br>Mona Martinez, Deputy Director<br><br>**DOH/DHI/QMB**<br>Bernadette D. Baca, MPA, Healthcare Surveyor<br>Lora Norby, Healthcare Surveyor |
| Exit Conference Date: | March 18, 2022 |
| Present: | **Citizens for the Developmentally Disabled**<br>Bobby LeDoux, Executive Director<br>Cassandra Gonzales, Site Director/Service Coordinator<br>Anita Lopez, Director of Nursing / RN<br>Mona Martinez, Deputy Director<br><br>**DOH/DHI/QMB**<br>Verna Newman-Sikes, AA, Team Lead/Healthcare Surveyor<br>Kayla R Benally, BSW, Healthcare Surveyor<br>Joshua Burghart, BS, Healthcare Surveyor<br>Lora Norby, Healthcare Surveyor<br>Wolf Krusemark, BFA, Healthcare Surveyor Supervisor<br><br>**DDSD - NE Regional Office**<br>Fabian Lopez, Social Community Service Coordinator |
| Total Sample Size: | 5<br><br>1 - *Jackson* Class Members<br>4 - Non-*Jackson* Class Members<br><br>3 - Supported Living<br>1 - Family Living<br>1 - Customized In-Home Supports<br>5 - Customized Community Supports |
| Total Homes Visited | 3 |
| ❖ Supported Living Homes Visited | 2<br>*Note: The following Individuals share a SL residence:*<br>➢ #4, 5 |
| ❖ Family Living Homes Visited | 1 |

| | |
|---|---|
| Persons Served Records Reviewed | 5 |
| Persons Served Interviewed | 5 |
| Direct Support Personnel Records Reviewed | 15 |
| Direct Support Personnel Interviewed | 4 *(Note: Interviews conducted by video / phone due to COVID-19 Public Health Emergency)* |
| Service Coordinator Records Reviewed | 1 |
| Nurse Interview | 1 |

Administrative Processes and Records Reviewed:

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

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

**Attachment A**

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

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

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

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

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 505-273-1930 or email at MonicaE.Valdez@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment C).

***Instructions for Completing Agency POC:***

***Required Content***
Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice cited to prevent recurrence and information that ensures the regulation cited comes into and remains in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance (QA) Plan.

If a deficiency has already been corrected since the on-site survey, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

*The following details should be considered when developing your Plan of Correction:*

***The Plan of Correction must address each deficiency cited in the Report of Findings unless otherwise noted with a "No Plan of Correction Required statement." The Plan of Correction must address the five (5) areas listed below:***

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented, and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

*The following details should be considered when developing your Plan of Correction:*

- Details about how and when Individual Served, agency personnel and administrative and service delivery site files are audited by agency personnel to ensure they contain required documents;
- Information about how medication administration records are reviewed to verify they contain all required information before they are distributed to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (LOC) packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

***Note:*** **Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps must be taken to ensure the deficiency is corrected and will not recur.

***Completion Dates***

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

***Initial Submission of the Plan of Correction Requirements***

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Monica Valdez, POC Coordinator in any of the following ways:
    a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108
5. *Do not submit supporting documentation* (evidence of compliance) to QMB *until after* your POC has been approved by the QMB.
6. QMB will notify you when your POC has been "approved" or "denied."
    a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45-business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
    b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.
    c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

***POC Document Submission Requirements***

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a *maximum* of 45-business days of receipt of your Report of Findings.

2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If documents containing HIPAA Protected Health Information (PHI) documents must be submitted through S-Comm (Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to e-mails.
3. All submitted documents *must be annotated*; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

**Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the completion date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.**

**Attachment B**

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

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

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

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

**Conditions of Participation (CoPs)**

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

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

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

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

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

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

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

- **1A20 -** Direct Support Personnel Training
- **1A22 -** Agency Personnel Competency
- **1A37 –** Individual Specific Training

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

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

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

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

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

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

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

**Attachment C**

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

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

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

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

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

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

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

**Attachment D**

## QMB Determinations of Compliance

**Compliance:**

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

**Partial-Compliance with Standard Level Tags:**

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

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

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

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

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

**Non-Compliance:**

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

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

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

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

**Agency:** **Citizens for the Developmentally Disabled - Northeast Region**
Program: Developmental Disabilities Waiver
Service: Supported Living, Family Living, Customized In-Home Supports, and Customized Community Supports
Survey Type: Routine
**Survey Date:** **March 7-12, 2022**

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI and Responsible Party | Completion Date |
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| ***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** | | |
| **NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP.** The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.<br><br>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in | After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.<br><br>Based on 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 5 individuals.<br><br>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:<br><br>**Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**:<br><br>Individual #4<br>• None found regarding: Live Outcome/Action Step: "I will choose what I want to put in my scrapbook" for 1/2022. Action step is to be completed 1 time per week.<br><br>**Customized Community Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes**:<br><br>Individual #4 | **Provider:**<br>**State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| the 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.<br><br>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]<br><br>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019<br>**Chapter 6: Individual Service Plan (ISP) 6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.<br><br>**Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain | • None found regarding: Work/learn Outcome/Action Step: "I will select an aerobic activity" for 12/2021. Action step is to be completed 2 times per week.<br><br>• None found regarding: Work/learn Outcome/Action Step: "I will participate in the aerobic activity that I have chosen" for 12/2021. Action step is to be completed 2 times per week. | | |

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

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| 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. | | | |

| Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)* | Standard Level Deficiency | | |
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| **NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP.** The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.<br><br>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.<br><br>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. | 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 2 of 5 individuals.<br><br>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:<br><br>**Supported Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes**:<br><br>Individual #4<br>• According to the Live Outcome; Action Step for "I will choose what I want to put in my scrapbook" 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 11/2021 - 12/2021.<br><br>Individual #5<br>• According to the Live Outcome; Action Step for "with help of staff I will be prompted to help with laundry " 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 11/2021 - 1/2022.<br><br>• According to the Live Outcome; Action Step for "with help of staff I will consistently participate in folding/putting away laundry with less than 3 prompts " is to be completed 1 time per week. Evidence found indicated it was not being completed at the required | **Provider:**<br>**State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]<br><br>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019<br>**Chapter 6: Individual Service Plan (ISP) 6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.<br><br>**Chapter 20: Provider Documentation and Client Records 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: | frequency as indicated in the ISP for 11/2021 - 1/2022.<br><br>**Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**:<br><br>Individual #4<br>• According to the Work/Learn Outcome; Action Step for "I will select an aerobic activity" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2021 and 1/2022.<br><br>• According to the Work/Learn Outcome; Action Step for "I will participate in the aerobic activity that I have chosen" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2021 and 1/2022. | | |

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

| Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation) | Standard Level Deficiency | | |
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| **NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP.** The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.<br><br>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.<br><br>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. | Based on residential 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 4 individuals.<br><br>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:<br><br>**Supported Living Data Collection/Data Tracking / Progress with regards to ISP Outcomes**:<br><br>Individual #4<br>• None found regarding: Live Outcome/Action Step: "I will choose what I want to put in my scrapbook" for 3/1 – 4, 2022. Action step is to be completed 1 time per week. (Date of home visit: 3/10/2022) | **Provider:**<br>**State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]<br><br>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019<br>**Chapter 6: Individual Service Plan (ISP) 6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.<br><br>**Chapter 20: Provider Documentation and Client Records 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: | | | |

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| 15. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.<br>16. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable.<br>17. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.<br>18. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.<br>19. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.<br>20. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.<br>21. 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 # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements) | Condition of Participation Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019<br>**Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.<br>DD Waiver Provider Agencies are required to adhere to the following:<br>1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.<br>2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable.<br>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.<br>4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.<br>5. Each Provider Agency is responsible for | After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.<br><br>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 4 Individuals receiving Living Care Arrangements.<br><br>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:<br><br>**Health Care Plans:**<br>• Neuro Shunt (#5) | **Provider:**<br>**State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.<br>6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.<br>7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.<br><br>**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:<br>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 | | | |

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

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI and Responsible Party | Completion Date |
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| ***Service Domain: Health and Welfare –*** *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.* | | | |
| **Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)** | **Condition of Participation Level Deficiency** | | |
| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019<br>**Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.<br>DD Waiver Provider Agencies are required to adhere to the following:<br>1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.<br>2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable.<br>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.<br>4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, | After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.<br><br>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 1 of 5 individuals<br><br>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:<br><br>**Healthcare Passport:**<br>➢ Did not contain Emergency Contact (#3) *(Note: Health Passport corrected during on-site survey. Provider please complete POC for ongoing QA/QI.)* | **Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.<br>5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.<br>6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.<br>7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.<br><br>**Chapter 3 Safeguards: 3.1.1 *Decision Consultation Process (DCP):*** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following:<br>1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to:<br>a. medical orders or recommendations from | | | |

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

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| d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.<br><br>**Chapter 13 Nursing Services: *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.<br>The following hierarchy is based on budgeted services and is used to identify which Provider Agency nurse has primary responsibility for completion of the nursing assessment process and related subsequent planning and training. Additional communication and collaboration for planning specific to CCS or CIE services may be needed.<br>The hierarchy for Nursing Assessment and Planning responsibilities is:<br>1. Living Supports: Supported Living, IMLS or Family Living via ANS;<br>2. Customized Community Supports- Group; and<br>3. Adult Nursing Services (ANS):<br>a. for persons in Community Inclusion with health-related needs; or<br>b. if no residential services are budgeted but assessment is desired and health needs may exist.<br><br>***13.2.6 The Electronic Comprehensive Health Assessment Tool (e-CHAT)***<br>1. The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person. | | | |

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| 2. The nurse must see the person face-to-face to complete the nursing assessment. Additional information may be gathered from members of the IDT and other sources.<br>3. An e-CHAT is required for persons in FL, SL, IMLS, or CCS-Group. All other DD Waiver recipients may obtain an e-CHAT if needed or desired by adding ANS hours for assessment and consultation to their budget.<br>4. When completing the e-CHAT, the nurse is required to review and update the electronic record and consider the diagnoses, medications, treatments, and overall status of the person. Discussion with others may be needed to obtain critical information.<br>5. The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections.<br><br>***13.2.7 Aspiration Risk Management Screening Tool (ARST)***<br><br>***13.2.8 Medication Administration Assessment Tool (MAAT):***<br>1. A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting.<br>2. After completion of the MAAT, the nurse will present recommendations regarding the level of assistance with medication delivery (AWMD) to the IDT. A copy of the MAAT will be sent to all the team members two weeks before the annual ISP meeting and the original MAAT will be retained in the Provider Agency records.<br>3. Decisions about medication delivery are made by the IDT to promote a person's maximum independence and community integration. The IDT will reach consensus regarding which criteria the person meets, as indicated | | | |

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| by the results of the MAAT and the nursing recommendations, and the decision is documented this in the ISP.<br><br>**13.2.9 Healthcare Plans (HCP)*:***<br>1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans.<br>2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs plans that the nurse determines are warranted.<br><br>***13.2.10 Medical Emergency Response Plan (MERP):***<br>1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP. | | | |

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| 2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.<br><br>**Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and 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 # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living) | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019<br>**Chapter 10: Living Care Arrangements (LCA) 10.3.6 Requirements for Each Residence:** Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence:<br>1. has basic utilities, i.e., gas, power, water, and telephone;<br>2. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher;<br>3. has a general-purpose first aid kit;<br>4. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift;<br>5. has water temperature that does not exceed a safe temperature ($110^0$ F);<br>6. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP;<br>7. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy;<br>8. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding;<br>9. supports environmental modifications and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised | Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 1 of 3 Living Care Arrangement residences.<br><br>Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:<br><br>**Supported Living Requirements:**<br><br>• Carbon monoxide detectors (#4, 5)<br><br>*Note: The following Individuals share a residence:*<br>➢ #4, 5 | **Provider:**<br>**State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI and Responsible Party | Completion Date |
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| ***Service Domain: Medicaid Billing/Reimbursement –*** *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.* | | | |
| **Tag # IS30 Customized Community Supports Reimbursement** | **Standard Level Deficiency** | | |
| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019<br>**Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following:<br>1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing.<br>2. Comprehensive documentation of direct service delivery must include, at a minimum:<br>a. the agency name;<br>b. the name of the recipient of the service;<br>c. the location of the service;<br>d. the date of the service;<br>e. the type of service;<br>f. the start and end times of the service;<br>g. the signature and title of each staff member who documents their time; and<br>h. the nature of services.<br>3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer.<br>4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any | Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 4 of 5 individuals.<br><br>Individual #2<br>November 2021<br>• The Agency billed 8 units of Customized Community Supports Group (T2021 HB U8) from 11/2/2021 through 11/3/2021. Documentation did not contain the required elements on 11/2/2021 through 11/3/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 8 units of Customized Community Supports Group (T2021 HB U8) on 11/5/2021. Documentation did not contain the required elements on 11/5/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 10 units of Customized Community Supports Individual (H2021 HB U1) from 11/11/2021 through 11/12/2021. Documentation did not contain the required elements on 11/11/2021 through 11/12/2021. Documentation received accounted for 0 units. The required element was not met: | **Provider:**<br>**State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| of the following for a period of at least six years from the payment date:<br>a. treatment or care of any eligible recipient;<br>b. services or goods provided to any eligible recipient;<br>c. amounts paid by MAD on behalf of any eligible recipient; and<br>d. any records required by MAD for the administration of Medicaid.<br><br>**21.9 Billable Units:** The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units.<br><br>**21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following:<br>1. A day is considered 24 hours from midnight to midnight.<br>2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period.<br>3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months.<br>4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows:<br>a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%).<br>b. The receiving Provider Agency bills the remaining days up to 340 for the ISP | ➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Group (T2021 HB U8) on 11/12/2021. Documentation did not contain the required elements on 11/12/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 4 units of Customized Community Supports Individual (H2021 HB U1) on 11/14/2021. Documentation did not contain the required elements on 11/14/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 4 units of Customized Community Supports Individual (H2021 HB U1) on 11/18/2021. Documentation did not contain the required elements on 11/18/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 3 units of Customized Community Supports Individual (H2021 HB U1) on 11/21/2021. Documentation did not contain the required elements on 11/21/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service. | | |

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| year.<br><br>**21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following:<br>1. A month is considered a period of 30 calendar days.<br>2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed.<br>3. Monthly units can be prorated by a half unit.<br>4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit.<br><br>**21.9.3 Requirements for 15-minute and hourly units**: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:<br>1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2.<br>2. Services that last in their entirety less than eight minutes cannot be billed. | • The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 11/25/2021. Documentation did not contain the required elements on 11/25/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>December 2021<br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 12/2/2021. Documentation did not contain the required elements on 12/2/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 12/5/2021. Documentation did not contain the required elements on 12/5/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 4 units of Customized Community Supports Individual (H2021 HB U1) on 12/8/2021. Documentation did not contain the required elements on 12/8/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service. | | |

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| | • The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 12/19/2021. Documentation did not contain the required elements on 12/19/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>January 2022<br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 1/9/2022. Documentation did not contain the required elements on 1/9/2022. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 1/23/2022. Documentation did not contain the required elements on 1/23/2022. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>Individual #3<br>November 2021<br>• The Agency billed 1 unit of Customized Community Supports Individual (H2021 HB U1) on 11/19/2021. Documentation did not contain the required elements on 11/19/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service. | | |

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| | Individual #4<br>November 2021<br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 11/1/2021. Documentation did not contain the required elements on 11/1/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 11/8/2021. Documentation did not contain the required elements on 11/8/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Group (T2021 HB U8) on 11/10/2021. Documentation did not contain the required elements on 11/10/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Group (T2021 HB U8) on 11/13/2021. Documentation did not contain the required elements on 11/13/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service. | | |

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| | • The Agency billed 4 units of Customized Community Supports Group (T2021 HB U8) on 11/20/2021. Documentation did not contain the required elements on 11/20/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>December 2021<br>• The Agency billed 5 units of Customized Community Supports Individual (H2021 HB U1) on 12/8/2021. Documentation did not contain the required elements on 12/8/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 7 units of Customized Community Supports Individual (H2021 HB U1) on 12/15/2021. Documentation received accounted for 6 units.<br><br>• The Agency billed 1 units of Customized Community Supports Group (T2021 HB U8) on 12/16/2021. Documentation did not contain the required elements on 12/16/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 12/18/2021. Documentation did not contain the required elements on 12/18/2021. Documentation received | | |

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| | accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Group (T2021 HB U8) on 12/25/2021. Documentation did not contain the required elements on 12/25/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 1 unit of Customized Community Supports Individual (H2021 HB U1) on 12/27/2021. Documentation did not contain the required elements on 12/27/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>January 2022<br>• The Agency billed 3 units of Customized Community Supports Group (T2021 HB U8) on 1/21/2022. Documentation did not contain the required elements on 1/21/2022. Documentation received accounted for 1 unit. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Group (T2021 HB U8) on 1/25/2022. Documentation did not contain the required elements on 1/25/2022. Documentation received | | |

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| | accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>Individual #5<br>November 2021<br>• The Agency billed 2 units of Customized Community Supports Group (T2021 HB U8) on 11/10/2021. Documentation did not contain the required elements on 11/10/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 11/20/2021. Documentation did not contain the required elements on 11/20/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>December 2021<br>• The Agency billed 1 unit of Customized Community Supports Group (T2021 HB U8) on 12/1/2021. Documentation did not contain the required elements on 12/1/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Group (T2021 HB U8) on 12/3/2021. Documentation did not contain the required elements on | | |

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| | 12/3/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 12/4/2021. Documentation did not contain the required elements on 12/4/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 12/6/2021. Documentation did not contain the required elements on 12/6/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 12/10/2021. Documentation did not contain the required elements on 12/10/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 1 unit of Customized Community Supports Group (T2021 HB U8) on 12/22/2021. Documentation did not contain the required elements on 12/22/2021. Documentation received | | |

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| | accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 12/24/2021. Documentation did not contain the required elements on 12/24/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Group (T2021 HB U8) on 12/25/2021. Documentation did not contain the required elements on 12/25/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 1 unit of Customized Community Supports Individual (H2021 HB U1) on 12/27/2021. Documentation did not contain the required elements on 12/27/2021. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 12/31/2021. Documentation did not contain the required elements on 12/31/2021. Documentation received accounted for 0 units. The required element was not met: | | |

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| | ➢ Services were provided concurrently with another service.<br><br>January 2022<br>• The Agency billed 2 units of Customized Community Supports Individual (H2021 HB U1) on 1/4/2022. Documentation did not contain the required elements on 1/4/2022. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 2 units of Customized Community Supports Group (T2021 HB U8) on 1/25/2022. Documentation did not contain the required elements on 1/25/2022. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service.<br><br>• The Agency billed 4 units of Customized Community Supports Individual (H2021 HB U1) on 1/28/2022. Documentation did not contain the required elements on 1/28/2022. Documentation received accounted for 0 units. The required element was not met:<br>➢ Services were provided concurrently with another service. | | |

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

Date: June 16, 2022

To: Bobby LeDoux, Executive Director

Provider: Citizens for the Developmentally Disabled
Address: 230 4th Avenue
State/Zip: Raton, New Mexico87740

E-mail Address: Bobby@bacavalley.com

Region: Northeast
Survey Date: March 7 - 18, 2022

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Supported Living, Family Living, Customized In-Home Supports, and Customized Community Supports

Survey Type: Routine

Dear Mr. LeDoux:

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

**The Plan of Correction process is now complete.**

**Furthermore, your agency is now determined to be in Compliance with all Conditions of Participation.**

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

Consistent use of these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Monica Valdez, BS

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

Q.22.3.DDW.D0208.2.RTN.09.22.167