NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

| | |
|---|---|
| Date: | January 17, 2024 |
| To: | Elizabeth Rodriguez, CEO |
| Provider:<br>Address:<br>State/Zip: | A First Step, LLC<br>9301 Indian School Rd Suite 204,<br>Albuquerque, New Mexico 87112 |
| E-mail Address: | erodriguez@afirststepllc.com |
| Region:<br>Survey Date: | Metro, Southeast, and Southwest<br>December 4 - 18, 2023 |
| Program Surveyed: | Developmental Disabilities Waiver |
| Service Surveyed: | Family Living, Customized In-Home Supports, and Customized Community Supports |
| Survey Type: | Routine |
| Team Leader: | Kaydee Conticelli, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau |
| Team Members: | Lundy Tvedt, BA, JD, Healthcare Surveyor Supervisor; Liz Vigil, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Sally Rel, MS., Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau. |

Dear Ms. Rodriguez;

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 # 1A20 Direct Support Professional Training

The following tags are identified as Standard Level:

- Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components
- Tag # 1A37 Individual Specific Training
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider
- Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)

**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, Monica Valdez, Plan of Correction Coordinator** at MonicaE.Valdez@doh.nm.gov

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
PO Box 2348
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@hsd.nm.gov)*

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
5300 Homestead Rd NE, Suite 300-331
Albuquerque, NM 87110
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@doh.nm.gov 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,

Kaydee Conticelli

Kaydee Conticelli
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

**Survey Process Employed:**

| | |
|---|---|
| Administrative Review Start Date: | December 4,2023 |
| Contact: | **A First Step, LLC**<br>Elizabeth Rodriquez, CEO<br><br>**DOH/DHI/QMB**<br>Kaydee Conticelli, Team Lead/Healthcare Surveyor |
| Entrance Conference Date: | December 4,2023 |
| Present: | **A First Step, LLC**<br>Elizabeth Rodriquez, CEO<br>Christina Mendoza, Service Coordinator<br><br>**DOH/DHI/QMB**<br>Kaydee Conticelli, Team Lead / Healthcare Surveyor<br>Lundy Tvedt, BA, JD, Healthcare Surveyor Supervisor<br>Elizabeth Vigil, Healthcare Surveyor<br>Sally Rel, MS, Healthcare Surveyor |
| Exit Conference Date: | December 15, 2023 |
| Present: | **A First Step, LLC**<br>Sherease Amaya, Service Coordinator<br>Elizabeth Rodriguez, CEO<br>Christina Mendoz, Service Coordinator<br>Arvel Rodriguez, Billing Officer<br>Benito Mendoza, Billing Coordinator<br><br>**DOH/DHI/QMB**<br>Sally Karingada, BS, Healthcare Surveyor Supervisor<br>Valerie V. Valdez, MS, QMB Bureau Chief<br>Elizabeth Vigil, Healthcare Surveyor<br>Sally Rel, MS, Healthcare Surveyor |
| Total Wellness Visits Completed: | 13 |
| Total Survey Sample Size: | 13<br><br>6 - Family Living<br>4 - Customized In-Home Supports<br>4 - Customized Community Supports |
| Total Home Visits | 10 |
| ❖ Family Living Homes Visited | 6 |
| ❖ Customized In-Home Support Home Visited | 4 |
| Persons Served Records Reviewed | 13 |
| Persons Served Interviewed | 13 |
| Direct Support Professional Records Reviewed | 25 |

| | |
|---|---|
| Direct Support Professional Interviewed | 8 |
| Substitute Care / Respite Personnel Records Reviewed | 9 |
| Service Coordinator Records Reviewed | 3 |
| Administrative Interview | 1 |
| Nurse Interview | 1 |

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
    - °Individual Service Plans
    - °Progress on Identified Outcomes
    - °Healthcare Plans
    - °Medical Emergency Response Plans
    - °Medication Administration Records
    - °Physician Orders
    - °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
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
HSD - Medical Assistance Division

**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@doh.nm.gov. 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@doh.nm.gov 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 via email at MonicaE.valdez@doh.nm.gov. Please also submit your POC to your Developmental Disabilities Supports Division Regional Office for region of service surveyed.
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. You must also submit evidence of the ongoing Quality Assurance/Quality Improvement processes.

1. Your internal documents are due within a *maximum* of 45-business days of receipt of your Report of Findings.
2. Please submit your documents electronically according to the following: If documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to the State email account. If documents contain PHI **do not** submit PHI directly to the State email account. *You may submit PHI **only** when **replying** to a **secure** email received from the State email account*. When possible, please submit requested documentation using a "zipped/compressed" file to reduce file size. You may also submit documents via S-Comm (Therap), or another electronic format, i.e., flash drive.
3. All submitted documents *must be annotated*; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

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

**Attachment B**

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

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

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

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

**Conditions of Participation (CoPs)**

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

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

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

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

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

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

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

- **1A20 -** Direct Support Professional 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%:**
- **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
- **1A08.2** – Administrative Case File: Healthcare Requirements & Follow-up
- **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: Microsoft Word - IRF-QMB-Form.doc (nmhealth.org)
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@doh.nm.gov 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. | | | | | |

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI and Responsible Party | Completion Date |
|---|---|---|---|
| ***Service Domain: Service Plans: ISP Implementation –*** *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.* | | | |
| **Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components** | **Standard Level Deficiency** | | |
| **NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY.**<br><br>**NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS.**<br><br>**NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.**<br><br>Developmental Disabilities Waiver Service Standards Eff 11/1/2021<br>**Chapter 6 Individual Service Plan (ISP)** The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP.<br><br>**6.6 DDSD ISP Template:** The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e., an acknowledgement of receipt of specific information) and other elements depending on the age and status of the individual. The ISP | Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 13 individuals.<br><br>Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current:<br><br>**Addendum A**:<br>• Not Found (#17) | **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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| templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use to better demonstrate required elements of the PCP process and ISP development.<br>**6.6.1 Vision Statements: The long-term vision statement describes the person's major long-term (e.g., within one to three years) life dreams and aspirations in the following areas:**<br>1. Live,<br>2. Work/Education/Volunteer,<br>3. Develop Relationships/Have Fun, and<br>4. Health and/or Other (Optional).<br>**6.6.2 Desired Outcomes:** A Desired Outcome is required for each life area (Live, Work, Fun) for which the person receives paid supports through the DD Waiver. Each service does not need its own, separate outcome, but should be connected to at least one Desired Outcome.<br>**6.6.3.1 Action Plan:** Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes.<br>**6.6.3.2 Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI):** After the ISP meeting, IDT members conduct a task analysis and assessments necessary to create effective TSS and WDSI to support those Action Plans that require this extra detail.<br>**6.6.3.3 Individual Specific Training in the ISP:** The CM, with input from each DD Waiver Provider Agency at the annual ISP meeting, completes the IST requirements section of the ISP form listing all training needs specific to the individual.<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 | | | |

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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. | | | |

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI and Responsible Party | Completion Date |
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| ***Service Domain: Qualified Providers –*** *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.* | | | |
| **Tag # 1A20 Direct Support Professional Training** | **Condition of Participation Level Deficiency** | | |
| Developmental Disabilities Waiver Service Standards Eff 11/1/2021<br>**Chapter 17 Training Requirements: 17.1 Training Requirements for Direct Support Professional and Direct Support Supervisors:** Direct Support Professional (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports.<br>1. DSP/DSS must successfully complete within 30 calendar days of hire and prior to working alone with a person in service:<br>a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in Chapter 17.9 Individual Specific Training below.<br>b. Complete DDSD training in standards precautions located in the New Mexico Waiver Training Hub.<br>c. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines.<br>d. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals).<br>e. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, Crisis Prevention and Intervention (CPI)) before using Emergency Physical Restraint (EPR). Agency DSP and DSS shall maintain certification in a DDSD-approved system if any person they | 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 ensure Orientation and Training requirements were met for 14 of 28 Direct Support Professional, Direct Support Supervisory Personnel and / or Service Coordinators.<br><br>Review of Agency training records found no evidence of the following required DOH/DDSD trainings being completed:<br><br>**First Aid:**<br>• Not Found (#502, 503, 505, 512, 513, 515, 516, 518, 519, 522, 523, 526, 528, 529)<br><br>**CPR:**<br>• Not Found (#502, 503, 505, 512, 513, 515, 516, 518, 519, 522, 523, 526, 528, 529)<br><br>**Assisting with Medication Delivery:**<br>• Not Found (#506) | **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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| support has a BCIP that includes the use of EPR.<br>f. Complete and maintain certification in a DDSD-approved Assistance with Medication Delivery (AWMD) course if required to assist with medication delivery.<br>g. Complete DDSD training regarding the HIPAA located in the New Mexico Waiver Training Hub.<br><br>**17.1.13 Training Requirements for Service Coordinators (SC):** Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports.<br>1. A SC must successfully complete within 30 calendar days of hire and prior to working alone with a person in service:<br>a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported, and as outlined in the Chapter 17.10 Individual-Specific Training below.<br>b. Complete DDSD training in standard precautions located in the New Mexico Waiver Training Hub.<br>c. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines.<br>d. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals).<br>e. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using emergency physical restraint. Agency SC shall maintain certification in a DDSD- | | | |

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| approved system if a person they support has a Behavioral Crisis Intervention Plan that includes the use of emergency physical restraint.<br>f. Complete and maintain certification in AWMD if required to assist with medications.<br>g. Complete DDSD training regarding HIPAA located in the New Mexico Waiver Training Hub. | | | |

| Tag # 1A37 Individual Specific Training | Standard Level Deficiency | | |
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| Developmental Disabilities Waiver Service Standards Eff 11/1/2021<br>**Chapter 17 Training Requirements: 17.1 Training Requirements for Direct Support Professional and Direct Support Supervisors:** Direct Support Professional (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports.<br>1. DSP/DSS must successfully complete within 30 calendar days of hire and prior to working alone with a person in service:<br>a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in Chapter 17.9 Individual Specific Training below.<br>b. Complete DDSD training in standards precautions located in the New Mexico Waiver Training Hub.<br>c. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines.<br>d. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals).<br>e. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, Crisis Prevention and Intervention (CPI)) before using Emergency Physical Restraint (EPR). Agency DSP and DSS shall maintain certification in a DDSD-approved system if any person they support has a BCIP that includes the use of EPR.<br>f. Complete and maintain certification in a DDSD-approved Assistance with Medication Delivery (AWMD) course if required to assist with medication | Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 3 of 28 Agency Personnel.<br><br>Review of personnel records found no evidence of the following:<br><br>**Direct Support Professional (DSP):**<br>• Individual Specific Training (#519, 506)<br><br>**Service Coordination Personnel (SC):**<br>• Individual Specific Training (#530) | **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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| delivery.<br>g. Complete DDSD training regarding the HIPAA located in the New Mexico Waiver Training Hub.<br><br>**17.1.13 Training Requirements for Service Coordinators (SC):** Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports.<br>2. A SC must successfully complete within 30 calendar days of hire and prior to working alone with a person in service:<br>a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported, and as outlined in the Chapter 17.10 Individual-Specific Training below.<br>b. Complete DDSD training in standard precautions located in the New Mexico Waiver Training Hub.<br>c. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines.<br>d. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals).<br>e. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using emergency physical restraint. Agency SC shall maintain certification in a DDSD-approved system if a person they support has a Behavioral Crisis Intervention Plan that includes the use of emergency physical restraint.<br>f. Complete and maintain certification in AWMD if required to assist with | | | |

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| medications.<br>g. Complete DDSD training regarding HIPAA located in the New Mexico Waiver Training Hub. | | | |

| 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 #1A08.2 Administrative Case File: Healthcare Requirements & Follow-up** | **Standard Level Deficiency** | | |
| Developmental Disabilities Waiver Service Standards Eff 11/1/2021<br>**Chapter 3 Safeguards: 3.1 Decisions about Health Care or Other Treatment: Decision Consultation and Team Justification Process:** There are a variety of approaches and available resources to support decision making when desired by the person. The decision consultation and team justification processes assist participants and their health care decision makers to document their decisions. It is important for provider agencies to communicate with guardians to share with the Interdisciplinary Team (IDT) Members any medical, behavioral, or psychiatric information as part of an individual's routine medical or psychiatric care. For current forms and resources please refer to the DOH Website: https://nmhealth.org/about/ddsd/.<br>**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 and Interdisciplinary Teams (IDTs) 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 Decision Consultation Process (DCP) is documented on the Decision Consultation and Team Justification Form (DC/TJF) and is used for health related issues when a person or their guardian/healthcare decision maker has concerns, needs more | Based on record review and interview, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 1 of 13 individuals receiving Living Care Arrangements and Community Inclusion.<br><br>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:<br><br>**Annual Physical *(LCA Only)*:**<br>• Not Found (#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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| information about these types of issues or has decided not to follow all or part of a healthcare-related order, recommendation, or suggestion. This includes, but is not limited to:<br>a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;<br>b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT (e.g., nurses, therapists, dieticians, BSCs or PRS Risk Evaluator) or clinicians who have performed evaluations such as a video-fluoroscopy;<br>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR); and<br>d. recommendations made by a licensed professional through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), a Medical Emergency Response Plan (MERP) or another plan such as a Risk Management Plan (RMP) or a Behavior Crisis Intervention Plan (BCIP).<br>**Chapter 20 Provider Documentation and Client Records: 20.2 Client Record 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 | | | |

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| 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 are acceptable.<br>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all 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 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>**20.5.4 Health Passport and Physician** | | | |

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| **Consultation Form:** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form generated from an e-CHAT in 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>1. The Case Manager and Primary and Secondary Provider Agencies must communicate critical information to each other and will keep all required sections of Therap updated in order to have a current and thorough *Health Passport* and *Physician Consultation* Form available at all times. Required sections of Therap include the IDF, Diagnoses, and Medication History.<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 in the IDF.<br>3. Primary and Secondary Provider Agencies must assure that the current *Health Passport* and *Physician Consultation* form accompany each person when taken by the provider to a medical appointment, urgent care, emergency room, or are admitted to a hospital or nursing home. (If the person is taken by a family member or guardian, the | | | |

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| *Health Passport* and *Physician Consultation* form must be provided to them.)<br>4. The Physician Consultation form must be reviewed, and any orders or changes must be noted and processed as needed by the provider within 24 hours.<br>5. Provider Agencies must document that the *Health Passport* and *Physician Consultation* form and Advanced Healthcare Directives were delivered to the treating healthcare professional by one of the following means:<br>a. document delivery using the *Appointments Results* section in *Therap Health Tracking Appointments*; and<br>b. scan the signed *Physician Consultation Form* and any provided follow-up documentation into Therap after the person returns from the healthcare visit.<br>**Chapter 13 Nursing Services: 13.2.3 General Requirements Related to Orders, Implementation, and Oversight**<br>1. Each person has a licensed primary care practitioner and receives an annual physical examination, dental care and specialized medical/behavioral care as needed. PPN communicate with providers regarding the person as needed.<br>2. Orders from licensed healthcare providers are implemented promptly and carried out until discontinued.<br>a. The nurse will contact the ordering or on call practitioner as soon as possible, or within three business days, if the order cannot be implemented due to the person's or guardian's refusal or due to other issues delaying implementation of the order. The nurse must clearly document the issues and all attempts to resolve the problems with all involved parties.<br>b. Based on prudent nursing practice, if a nurse determines to hold a practitioner's | | | |

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| order, they are required to immediately document the circumstances and rationale for this decision and to notify the ordering or on call practitioner as soon as possible, but no later than the next business day.<br>c. If the person resides with their biological family, and there are no nursing services budgeted, the family is responsible for implementation or follow up on all orders from all providers. Refer to Chapter 13.3 Adult Nursing Services. | | | |

| Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider | Standard Level Deficiency | | |
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| **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:**<br>**A. Duty to report:**<br>**(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers.<br>**(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety.<br><br>**B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident.<br><br>**C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:**<br>**(1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. | Based on interview and observation, the Agency did not report suspected abuse, neglect, or exploitation**,** unexpected and natural/expected deaths; or other reportable incidents as required to the Division of Health Improvement.<br><br>During the on-site survey on December 6, 2023, at 4:30pm, surveyors observed the following:<br><br>**Individual #10**<br>During the on-site visit on 12/6/2023 at approximately 4:30pm, Surveyors arrived at the individual's home, as the surveyors entered the home The following was observed:<br><br>• An intense odor of pet urine.<br><br>• The ceiling in between the living room and kitchen was bubbling inward from what appeared to be a leak in the roof. There was a plastic sheet that was approximately 5 feet by 5 feet covering the area. It was reported by the FLP that when it rains, etc. the ceiling leaks and that is why it is covered by the plastic covering.<br><br>• The front door to the home was observed with no doorknob or other device to secure the door.<br><br>• The kitchen had a leak under the sink. The boards under the sink were black in color and appeared to be disintegrating. FLP stated, "We have had a leak under the sink for a while."<br><br>Based on observation of the residence, an ANE was filed on 12/7/2023. | **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 abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll-free hotline number, 1-800-445-6242.<br>**(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation, or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise, it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form.<br>**(3) Limited provider investigation:** No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation.<br>**(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall:<br>**(a)** develop and implement an immediate action and safety plan for any potentially | | | |

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| endangered consumers, if applicable;<br>**(b)** be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and<br>**(c)** provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise, it may be submitted by faxing it to the division at 1-800-584-6057.<br>**(5) Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident.<br>**(6) Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative.<br>**(7) Case manager or consultant notification by community-based service providers:** The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant. | | | |

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| **(8) Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation. | | | |

| Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living) | Standard Level Deficiency | | |
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| Developmental Disabilities Waiver Service Standards Eff 11/1/2021<br>**Chapter 10 Living Care Arrangement (LCA):**<br>**10.3.7 Requirements for Each Residence:**<br>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, telephone, and internet access;<br>2. supports telehealth, and/ or family/friend contact on various platforms or using various devices;<br>3. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher;<br>4. has a general-purpose first aid kit;<br>5. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift;<br>6. has water temperature that does not exceed a safe temperature ($110^0$ F). Anyone with a history of being unsafe in or around water while bathing, grooming, etc. or with a history of at least one scalding incident will have a regulated temperature control valve or device installed in the home.<br>7. 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>8. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy;<br>9. has emergency evacuation procedures | Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 4 of 6 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>**Family Living Requirements:**<br><br>• General-purpose first aid kit (#10)<br><br>• Poison Control Phone Number (#1, 10, 12)<br><br>• Water temperature in home exceeds safe temperature ($110^0$ F)<br>  • Water temperature in home measured $142.0^0$ F (#14)<br><br>  • Water temperature in home measured $123.8^0$ F (#12) | **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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| that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding;<br>10. supports environmental modifications, remote personal support technology (RPST), and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;<br>11. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed;<br>12. has the phone number for poison control within line of site of the telephone;<br>13. has general household appliances, and kitchen and dining utensils;<br>14. has proper food storage and cleaning supplies;<br>15. has adequate food for three meals a day and individual preferences; and<br>16. has at least two bathrooms for residences with more than two residents.<br>17. Training in and assistance with community integration that include access to and participation in preferred activities to include providing or arranging for transportation needs or training to access public transportation.<br>18. Has Personal Protective Equipment available, when needed. | | | |

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI and Responsible Party | Completion Date |
|---|---|---|---|
| ***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 #1A12 All Services Reimbursement** | **No Deficient Practices Found** | | |
| **NMAC 8.302.2**<br><br>Developmental Disabilities Waiver Service Standards Eff 11/1/2021<br>**Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements**<br>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>3. Details of the services provided. 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 of the following for a period of at least | Based on record review, the Agency maintained all the records necessary to fully disclose the nature, quality, amount, and medical necessity of services furnished to an eligible recipient who is currently receiving DDW services for 13 of 13 individuals.<br><br>*Progress notes and billing records supported billing activities for the months of August, September, and October 2023 for the following services:*<br><br>• Family Living<br><br>• Customized In-Home Supports<br><br>• Customized Community Supports | | |

six years from the payment date:
a. treatment or care of any eligible recipient;
b. services or goods provided to any eligible recipient;
c. amounts paid by MAD on behalf of any eligible recipient; and
d. any records required by MAD for the administration of Medicaid.

**21.7 Billable Activities**:
Specific billable activities are defined in the scope of work and service requirements for each DD Waiver service. In addition, any billable activity must also be consistent with the person's approved ISP.

**21.9 Billable Units**: The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit, or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units.

**21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following:
1. A day is considered 24 hours from midnight to midnight.
2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period.
3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months.

**21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following:
1. A month is considered a period of 30 calendar days.
2. Face-to-face billable services shall be provided during a month when any portion of a monthly unit is billed.

| | | | |
|---|---|---|---|
| 3. Monthly units can be prorated by a half unit.<br><br>**21.9.4 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. | | | |

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date: March 19, 2024

To: Elizabeth Rodriguez, CEO

Provider: A First Step, LLC
Address: 9301 Indian School Rd Suite 204,
State/Zip: Albuquerque, New Mexico 87112

E-mail Address: erodriguez@afirststepllc.com

Region: Metro, Southeast, and Southwest
Survey Date: December 4 - 18, 2023

Program Surveyed: Developmental Disabilities Waiver

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

Survey Type: Routine

Dear Ms. Rodriguez:

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.24.2.DDW.42157030.3/4/5.RTN.09.24.079