NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

(Modified by IRF)

Date:	March 1, 2024
To:	Chelsey Hester, Operations Director
Provider: Address: State/Zip:	Ability First, LLC 2610 San Mateo Blvd. NE, Suite A Albuquerque, New Mexico 87110
E-mail Address:	chester@arizonaautism.com
CC:	rsherman@arizonaautism.com
Region: Survey Date:	Metro January 22 – February 2, 2024
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports, and Community Integrated Employment Services
Survey Type:	Routine
Team Leader:	Kaitlyn Taylor, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Wolf Krusemark, BFA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Ashley Gueths, BACJ, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Heather Driscoll, AA, AAS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Elizabeth Vigil, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Kayla Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Karlene Anderson, LMSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Armida Medina, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Koren Chandler, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jessica Maestas, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Monica Valdez, BS, Healthcare Surveyor Advanced / Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau; Nicole Devoti, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Hester;

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and

to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

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

Non-Compliance: This determination is based on noncompliance with 17 or more total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level tag or any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation
- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A25.1 Caregiver Criminal History Screening ***(Upheld by IRF)***
- Tag # 1A26.1 Employee Abuse Registry ***(Upheld by IRF)***
- Tag # 1A05 General Requirements / Agency Policy and Procedure Requirements
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A09 Medication Delivery Routine Medication Administration ***(Upheld by IRF)***
- Tag # 1A09.1 Medication Delivery PRN Medication Administration ***(Upheld by IRF)***
- Tag # 1A31 Client Rights / Human Rights

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File (Other Required Documents)
- Tag # 1A08.1 Administrative and Residential Case File: Progress Notes
- Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*
- Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)
- Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)
- Tag # 1A20 Direct Support Professional Training ***(Modified by IRF)***
- Tag # 1A26 Employee Abuse Registry ***(Modified by IRF)***
- Tag # 1A37 Individual Specific Training
- Tag # 1A43.1 General Events Reporting: Individual Reporting
- Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication
- Tag # 1A27.0 Immediate Action and Safety Plan ***(Modified by IRF)***
- Tag # 1A31.2 Human Right Committee Composition
- Tag # 1A33 Board of Pharmacy: Med. Storage
- Tag # LS06 Family Living Requirements
- Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)
- Tag # IS25 Community Integrated Employment Services
- Tag # IS30 Customized Community Supports Reimbursement
- Tag # LS26 Supported Living Reimbursement
- Tag # LS27 Family Living Reimbursement

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

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

Corrective Action for Current Citation:

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

On-going Quality Assurance/Quality Improvement Processes:

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

Submission of your Plan of Correction:

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

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

1. **Quality Management Bureau, Marie Passaglia, Plan of Correction Coordinator** at Marie.Passaglia@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, Marie Passaglia at 505-819-7344 or email at: Marie.Passaglia@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,

Kaitlyn Taylor, BSW

Kaitlyn Taylor, BSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	January 22, 2024
Contact:	**Ability First, LLC** Chelsey Hester, Operations Director **DOH/DHI/QMB** Kaitlyn Taylor, BSW, Team Lead/Healthcare Surveyor
Entrance Conference Date:	January 22, 2024
Present:	**Ability First, LLC** Chelsey Hester, Operations Director Ryan Sherman, Owner Brenda Resendiz, Programs Director Lynanne Gallegos, Supportive Living Director Nancy Castillo, Healthcare Director Veronica Bunton, Nurse **DOH/DHI/QMB** Armida Medina, Team Lead/Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Ashley Gueths, BACJ, Healthcare Surveyor Heather Driscoll, AA, AAS, Healthcare Surveyor Jessica Maestas, Healthcare Surveyor Karlene Anderson, LMSW, Healthcare Surveyor Kayla Benally, BSW, Healthcare Surveyor Koren Chandler, Healthcare Surveyor Elizabeth Vigil, Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator
Exit Conference Date:	February 2, 2024
Present:	**Ability First, LLC** Ryan Sherman, Owner Chelsey Hester, Operations Director Brenda Resendiz, Programs Director Nancy Castillo, Healthcare Director Julie Sullivan, HR Administrator Lynanne Gallegos, Supported Living Director Suzanne Thompson, Billing Director **DOH/DHI/QMB** Kaitlyn Taylor, BSW, Team Lead/Healthcare Surveyor Amanda Castaneda, MPA, Healthcare Surveyor Supervisor Kayla Benally, BSW, Healthcare Surveyor Armida Medina, Healthcare Surveyor Ashley Gueths, BACJ, Healthcare Surveyor Heather Driscoll, AA, AAS, Healthcare Surveyor Jessica Maestas, Healthcare Surveyor Karlene Anderson, LMSW, Healthcare Surveyor Koren Chandler, Healthcare Surveyor

Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator

DDSD - Metro Regional Office
Angelina Pohl, Office Secretary
Linda Clark, Assistant Director

Administrative Locations Visited:	*(Administrative portion of survey completed remotely)*
Total Wellness Visits Completed (Individuals Seen):	49
Total Compliance Survey Sample Size:	31 11 - Supported Living 12 - Family Living 4 - Customized In-Home Supports 13 - Customized Community Supports 3 - Community Integrated Employment
Total Homes Visits	23
❖ Supported Living Homes Visited	7 *Note: The following Individuals share a SL residence:* • #2, 9, 26 • #4, 17 • #21, 22
❖ Family Living Homes Visited	12
❖ Customized In-Home Support Home Visited	4
Persons Served Records Reviewed	31
Persons Served Interviewed	31
Direct Support Professional Records Reviewed	231 *(Note: Two DSPs perform dual roles as Service Coordinators)*
Direct Support Professional Interviewed	34
Substitute Care/Respite Personnel Records Reviewed	31
Service Coordinator Records Reviewed	7 *(Note: Two Service Coordinators perform dual roles as DSP)*
Administrative Interview	1
Nurse Interview	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Oversight of Individual Funds
- Individual Agency / Residential / Site Case Files, including, but not limited to:

    - Individual Service Plans
    - Progress on Identified Outcomes
    - Healthcare Plans
    - Medication Administration Records
    - Physician Orders
    - Therapy Plans
    - Healthcare Documentation Regarding Appointments and Required Follow-Up
    - Other Required Health Information / Therap Required Documents
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files:
    - Training Records
    - Caregiver Criminal History Screening Records
    - Consolidated Online Registry/Employee Abuse Registry
- Interviews with the Individuals and Agency Personnel
- 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 505-819-7344 or email at Marie.Passaglia@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, Marie Passaglia at 505-819-7344 or email at Marie.Passaglia@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 Marie Passaglia, POC Coordinator via email at Marie.Passaglia@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%:
- **1A08.2 –** Administrative Case File: Healthcare Requirements & Follow-up
- **1A09 –** Medication Delivery Routine Medication Administration
- **1A09.2 –** Medication Delivery Nurse Approval for PRN Medication
- **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
- **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.					

Agency: **Ability First, LLC - Metro Region**
Program: Developmental Disabilities Waiver
Service: Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports, and Community Integrated Employment Services
Survey Type: Routine
Survey Date: **January 22 – February 2, 2024**

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 Administrative Case File (Other Required Documents)	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 4 of 31 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Budget Worksheet:** • Not Found (#23) **Positive Behavioral Support Plan:** • Not Found (#6) **Behavior Crisis Intervention Plan:** • Not Found (#2) **Documentation of Guardianship/Power of Attorney:** • Not Found (#17, 23)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Therap web-based system using computers or mobile devices are acceptable. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. 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. 6. 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. 7. 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. 8. All records must be retained for six (6) years 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 # 1A08.1 Administrative and Residential Case File: Progress Notes	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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: … 5. 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. 6. 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. 7. 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.	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 2 of 31 Individuals. Review of the Agency individual case files revealed the following items were not found: **Residential Case File:** **Family Living Progress Notes/Daily Contact Logs:** • Individual #14 - None found for 1/1 – 23, 2024. *(Date of home visit: 1/24/2024)* • Individual #15 - None found for 1/19 – 23, 2024. *(Date of home visit: 1/24/2024)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	Standard Level Deficiency		
NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY. **NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.** Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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. **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 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. **6.6.1 Vision Statements: The long-term vision statement describes the person's major long-term (e.g., within one to three**	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 31 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Annual ISP:** • Not Found (#23) **Addendum A**: • Not Found (#23)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

years) life dreams and aspirations in the following areas: 1. Live, 2. Work/Education/Volunteer, 3. Develop Relationships/Have Fun, and 4. Health and/or Other (Optional) **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. **6.6.3.1 Action Plan:** Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes. Multiple service types may be included in the Action Plan under a single Desired Outcome. **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. **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. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant			

information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.			

Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	Condition of Participation Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 7 of 31 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #25 • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Live area. **Agency's Outcomes/Action Steps are as follows:** ◦ *"… will inventory his list of personal hygiene supplies with zero prompts 1x week."* **Annual ISP (9/2023 – 9/2024) Outcomes/Action Steps are as follows:** ◦ *"… will take inventory of supplies needed to purchase 1x week."* Individual #26 • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Live area.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 6: 6.10 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) … All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: … 6. 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. 7. The current Client File Matrix found in Appendix A: Client File Matrix details the	**Agency's Outcomes/Action Steps are as follows:** ◦ *"… will make his chosen recipe."* ◦ *"…will choose a new recipe to make at home."* **Annual ISP (4/2023 – 3/2024) Outcomes/Action Steps are as follows:** ◦ *"… will complete an arts and crafts project."* ◦ *"…will take a picture of his completed project."* **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • None found regarding: Fun Outcome/Action Step: ".... will participate in classes using FMAE funds to pay for them so he can meet people, socialize, and get comfortable doing activities with others 8x month" for 10/2023 - 12/2023. Action step is to be completed 8 times per month. Individual #3 • None found regarding: Live Outcome/Action Step: "... will purchase items needed for oil change" for 10/2023 - 12/2023. Action step is to be completed quarterly. Individual #20 • None found regarding: Work/Learn Outcome/Action Step: "…will choose an arts and crafts project from a menu" for 10/2023 - 12/2023. Action step is to be completed 1 time per month.		

minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.	• None found regarding: Work/Learn Outcome/Action Step: "…will complete her arts and crafts project in the community" for 10/2023 - 12/2023. Action step is to be completed 4 times per week. • No Outcomes or DDSD exemption/decision justification found for (T2021 HB U9) CCS Small Group Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver." **Customized In-Home Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #30 • None found regarding: Live Outcome/Action Step: "... will research camps in her area" for 10/2023. Action step is to be completed 1 time per month. **Customized Community Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #11 • None found regarding: Work/Learn Outcome/Action Step: "…will be presented with two options and choose one" for 10/2023 - 11/2023. Action step is to be completed 4 times per month. **Community Integrated Employment Services Data Collection / Data Tracking/Progress with regards to ISP Outcomes:** Individual #30		

	• None found regarding: Work/Learn Outcome/Action Step: "... will ask co-workers their names and have conversations with them so that she can better remember their names" for 10/2023. Action step is to be completed 1 time per week.		

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and	Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 5 of 31 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #2 • According to the Live Outcome; Action Step for "...will prepare the chosen recipe" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2023. Individual #19 • According to the Live Outcome; Action Step for "... will make his bed with verbal prompts" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2023 and 12/2023. • According to the Live Outcome; Action Step for "… will put his dirty clothes in the hamper" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2023 and 12/2023.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 6: 6.10 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) … All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: … 6. 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.	• According to the Live Outcome; Action Step for "... will organize his closet" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2023 - 12/2023. **Family Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes:** Individual #5 • According to the Work/Learn Outcome; Action Step for " ... will go to her activity in the community" 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 10/2023 – 11/2023. Individual #10 • According to the Live Outcome; Action Step for "Identify favorite music with strong beat" 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 10/2023. • According to the Live Outcome; Action Step for "Follow patterned movement to beat of music for 2 minutes" 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 10/2023. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #5		

7. 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.	• According to the Fun Outcome; Action Step for "... will go to her activity in the community" 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 10/2023 - 11/2023. Individual #18 • According to the Work/Learn Outcome; Action Step for " ...will select and participate in chosen activities 3 days per week" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2023.		

Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and	Based on 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 23 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Family Living Data Collection/Data Tracking / Progress with regards to ISP Outcomes:** Individual #14 • None found regarding: Live Outcome/Action Step: "... be reminded to pick up items after she is done playing 2 x week" for 1/1 – 19, 2023. Action step is to be completed 2 times per week. *(Date of home visit: 1/24/2024)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 6: 6.10 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) … All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: … 6. 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.			

7. 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.			

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. 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. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. 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,	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 9 of 31 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **Annual ISP:** • Not Current (#24) **ISP Teaching and Support Strategies:** ***Individual #3:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "… will complete oil change on his car." ***Individual #9:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "… will choose a physical activity menu 1x week." ***Individual #12:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "Brushing his teeth everyday 4x month." ***Individual #21:*** *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 6. 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. 7. 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. **20.3 Record Access for Direct Support Professionals (DSP) during Service Delivery:** DSP must have access to records, plans, and forms needed to adequately provide and document the type of service and specific scope of service being provided at the time. **20.5 Communication and Documentation in Therap:** Therap is a secure online documentation system required to be used by specific New Mexico DD Waiver Provider Agencies. Use of the required elements of Therap are intended to improve agency monitoring, health care coordination for individuals, and overall quality of services. **20.5.3 *Health Passport and Consultation Form*** **20.5.4 *Health Tracking*** **20.5.5 *Nursing Assessment Tracking*** **Chapter 13 Nursing Services: 13.2.9.1 Health Care Plans (HCP):** Health Care Plans are created to provide guidance for the Direct Support Professionals (DSP) to support health	• "will investigate the details of taking a trip to attend a hockey game (SL)." ***Individual #22:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "… will utilize her I-pad to choose 1 healthy meal option." • "…will eat a healthy dinner of her choice." ***Individual #26:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "… will choose a new recipe to make at home." • "… will make his chosen recipe 1x month." **Comprehensive Aspiration Risk Management Plan:** • Not Current (#17, 25)		

related issues. Approaches that are specific to nurses may also be incorporated into the HCP. Healthcare Plans are based upon the eCHAT and the nursing assessment of the individual's needs. 1. The Primary Provider Agency nurse (PPN) 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 that the nurse determines are warranted.			

Tag # LS14.1 Residential Service Delivery Site Case File (Other Req. Documentation)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. 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. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. 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,	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 7 of 23 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: **Positive Behavioral Supports Plan:** • Not Found (#6, 11, 12, 13, 15) • Not Current (#2, 17) **Behavior Crisis Intervention Plan:** • Not Current (#2, 17)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

progress notes, and any other interactions for which billing is generated. 6. 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. 7. 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.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
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 *(Modified by IRF)*	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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… The training shall address at least the following: • Individual Specific Training • First Aid • CPR • Assisting With Medication Delivery (AWMD) Part 1 Session 1 & 2 **…** **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…The training shall address at least the following: • Individual Specific Training • First Aid • CPR • Assisting With Medication Delivery (AWMD) Part 1 Session 1 & 2 … ***(see DDW Standards Chapter 17 Training Requirements for all training specifics)***	Based on record review, the Agency did not ensure Orientation and Training requirements were met for 33 of 234 Direct Support Professional, Direct Support Supervisory Personnel and / or Service Coordinators. Review of Agency training records found no evidence of the following required DOH/DDSD trainings being completed: **First Aid:** • Not Found (#545, 672, 717, 724) • Expired (#629) **CPR:** • Not Found (#672, 717, 724) • Expired (#629) **Assisting with Medication Delivery:** • Not Found (#504, 511, 514, 525, 532, 533, 536, 541, 543, 545, 556, 581, ~~591~~, 603, 605, 622, 625, 626, 636, 643, 645, 650, 660, 673, 681, 690, 695, 707, 713, 731) *(Tag is modified by IRF. Finding for DSP #591 will be removed and all other findings for AWMD will be upheld.)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

Tag # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 17 Training Requirements:** **17.9 Individual-Specific Training Requirements:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. The trainer must observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 10 of 34 Direct Support Professional. **When DSP were asked, what State Agency do you report suspected Abuse, Neglect or Exploitation to, the following was reported:** • DSP #760 stated, "I do not, but I don't see any numbers." Staff was not able to identify the State Agency as Division of Health Improvement or Adult Protective Services. **When DSP were asked to give examples of Abuse, Neglect and Exploitation, the following was reported:** • DSP #504 identified Neglect as, " Bruising around her eyes or on her hip and she's emotional sometimes." Additionally, when asked about exploitation DSP stated, "Um okay, where I would say something that's negative. I would exploit her." • DSP #559 stated, "Having him do something he doesn't want to do." DSP's response with regards to Exploitation. • DSP #607 stated, "I don't know." DSP's response with regards to Exploitation. • DSP #678 stated, "I don't know." DSP's response with regards to Exploitation. • DSP #681 stated, "I'm not sure how to explain that one. I know what it is but let me	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported…	just skip it because it's not coming." DSP's response with regards to Exploitation. **When DSP were asked, if they knew what the Individual's health condition / diagnosis or when the information could be found, the following was reported:** • DSP #760 stated, "So, I know she is quite overweight, but other than that I am not too sure." Per the Health Passport, the Individual has a diagnosis of Asthma, Hypothyroidism, Lymphedema, Migraine, Type II Diabetes, and Venous Insufficiency. (Individual #21) **When DSP were asked, if the Individual's had Health Care Plans, where could they be located and if they had been trained, the following was reported:** • DSP #568 stated, "Seizures". As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires Health Care Plans for Falls and Pain. (Individual #24) **When DSP were asked, if the Individual had any food and / or medication allergies that could be potentially life threatening, the following was reported:** • DSP #632 stated, "No, I don't remember". "No, I don't remember if he has any. He used to a long time ago, I don't remember". As indicated by the Health Passport the individual is allergic to Amoxicillin. (Individual #3) • DSP #769 stated, "Food allergies no... Medications let me grab that ... An antibiotic that he is allergic to ugmedin [sic] not sure if		

	I spelled it correctly It causes him a rash". As indicated by the Health Passport the individual is allergic to Benzoyl Peroxide, Keppra, Oxcarbazepine, Phenobarbital. (Individual #18) • DSP #760 stated, "Not that I am aware of. She has not said she does so as far as I know she does not. No one has told me prior so I don't think she does." As indicated by the Health Passport the individual is allergic to Adhesive tape, Bactrim, Codeine, Latex, Natural rubber, Nystatin, Penicillin, Tetanus vaccines and Toxoid. (Individual #21) • DSP #504 stated, "Ya know it's funny that you ask that, because for the longest time it said that she's allergic to peanuts but I went ahead and got her tested and she is not allergic at all." As indicated by the Health Passport the individual is allergic to Penicillin. (Individual #30) • DSP #618 stated, "I don't think so, but I'm not sure." As indicated by the Health Passport the individual is allergic to Penicillin. (Individual #30)		

Tag # 1A25.1 Caregiver Criminal History Screening *(Upheld by IRF)*	Condition of Participation Level Deficiency		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **A. General:** The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (Amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider] to impose appropriate administrative sanctions and penalties. **B. Exception:** A caregiver or hospital caregiver applying for employment or contracting services with a care provider within twelve (12) months of the caregiver's or hospital caregiver's most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation indicating Caregiver Criminal History Screening was completed as required for 6 of 265 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Direct Support Professional (DSP):** • #511 – Date of hire 5/31/2019. • #550 – Date of hire 1/11/2022. • #561 – Date of hire 7/20/2020. • #579 – Date of hire 4/30/2010. • #584 – Date of hire 8/21/2023. • #646 – Date of hire 4/25/2020. *(Findings for DSP #511, 550, 561, 579, 584, 646 Upheld by IRF)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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

NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection. Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 16 Qualified Provider Agencies:** **16.1 Caregivers Criminal History Screening Program:** The Caregivers Criminal History Screening Program (CCHSP) is essential to the enforcement of the DOH policy of “Zero Tolerance” of Abuse, Neglect and Exploitation (ANE) and to the DHI mission of enhancing the			

quality of health systems for all New Mexicans… 1. For the purposes of the DD Waiver, the CCHSP applies to any non-licensed person whose employment, contractual or volunteer service with a DD Waiver Provider Agency includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that Provider Agency including: a. DSP, Direct Support Supervisors and Service Coordinators for CCS, CIE, Respite, CIHS, and Living Supports (Family Living, Supported Living, and IMLS); b. any unlicensed CMs; c. administrators or operators of facilities who are routinely on site where support is provided; d. any unlicensed providers of SSE; and e. any compensated persons such as employees, contractors, volunteers, and employees of contractors. 2. All non-licensed personnel must obtain a caregiver criminal history screening background check within 20 calendar days of hire (NMAC7.1.9). Provider Agencies must also check the EAR prior to hiring or contracting with an employee (NMAC 7.1.12). 3. Individuals with a disqualifying criminal conviction or who have been placed on the EAR for a substantiation of ANE are not eligible to work as a caregiver or have access to patient/client/resident information or records.			

Tag # 1A26 Employee Abuse Registry *(Modified by IRF)*	Standard Level Deficiency		
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 6 of 265 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Professional (DSP):** • #524 – Date of hire 6/15/2022, completed 2/22/2023. • #530 – Date of hire 5/1/2023, completed 7/25/2023. • #551 – Date of hire 9/14/2022, completed 11/8/2023. • #640– Date of hire 4/3/2023, completed 8/15/2023. • #664 – Date of hire 10/7/2022, completed 11/28/2022. • #698 – Date of hire 11/1/2022, completed 3/28/2023. ~~**Service Coordination Personnel (SC):**~~ ~~• #733 – Date of hire 11/9/2021, completed 10/31/2023.~~ *(Findings for DSP # 524, 530, 551, 640, 664, 698 are upheld by IRF. Finding for SC #733 will be removed.)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

of birth, social security number, and other appropriate identifying information required by the registry. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.			

Tag # 1A26.1 Employee Abuse Registry *(Upheld by IRF)*	Condition of Participation Level Deficiency		
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 6 of 265 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:** **Direct Support Professional (DSP):** • #518 – Date of hire 8/12/2010. • #579 – Date of hire 4/30/2010. • #590 – Date of hire 8/8/2013. • #600 – Date of hire 3/2/2021. • #632 – Date of hire 2/13/2006. • #672 – Date of hire 5/5/2023. *(Findings for DSP #518, 579, 590, 600, 632, 672 Upheld by IRF)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

of birth, social security number, and other appropriate identifying information required by the registry. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.			

Tag # 1A37 Individual Specific Training	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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… The training shall address at least the following: • Individual Specific Training **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…The training shall address at least the following: • Individual Specific Training **17.9 Individual-Specific Training Requirements:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill… Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported…	Based on record and interview review, the Agency did not ensure that Individual Specific Training requirements were met for 19 of 234 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Professional (DSP):** • Individual Specific Training (#525, 529, 537, 562, 581, 584, 612, 617, 632, 636, 643, 644, 668, 674, 694, 704, 705, 718) **Service Coordination Personnel (SC):** • Individual Specific Training (#731) **When DSP were asked, if they were provided with Individual Specific Training for the Individual they are supporting, the following was reported:** • DSP #636 stated, “Not much, it's all on the job training. To be honest I haven't got much training.” (Individual #27)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A43.1 General Events Reporting: Individual Reporting	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 19 Provider Reporting Requirements: *19.2 General Events Reporting (GER):*** The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Non-compliance with GER requirements may result in DDSD Contract Management actions including but not limited to the imposition of Civil Monetary Penalties. Provider Agency use of GER in Therap is required as follows: 1. DD Waiver Provider Agencies approved to provide Customized In- Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use the GER … 2. The following events must be reported in GER: a. Emergency Room/Urgent Care/Emergency Medical Services b. Falls Without Injury c. Person not eating, drinking or receiving nutritional or hydration support for more than 48 hours d. Injury (including Falls, Choking, Skin Breakdown and Infection)	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 4 of 31 individuals. **The following events were not reported in the General Events Reporting System as required by policy:** **Individual #2** • Documentation reviewed indicates on 5/13/2023 the Individual went to the Emergency Room (Emergency Services). No GER was found. • Documentation reviewed indicates on 5/29/2023 the Individual went to the Emergency room (Emergency Services). No GER was found. **Individual #9** • Documentation reviewed indicates on 10/27/2023 the Individual was taken to urgent care (Urgent Care). No GER was found. **Individual #10** • Documentation reviewed indicates on 10/18/2023 the Individual went to urgent care for g-tube issues (Emergency Medicine). No GER was found. **Individual #17** • Documentation reviewed indicates on 7/31/2023 the Individual went to urgent care for neck abscess (Urgent Care). No GER was found. • Documentation reviewed indicates on 8/25/2023 the Individual went to urgent	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

e. Law Enforcement Use f. All Medication Errors g. Medication Documentation Errors h. Missing Person/Elopement **i.** Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission j. PRN Psychotropic Medication k. Restraint Related to Behavior l. Suicide Attempt or Threat 3. Reporting Provider Agencies must have a system in place to enter information into and approve GERs per Appendix B GER Requirements and as identified by DDSD. 4. Each agency that is required to participate in General Event Reporting via Therap should ensure information from the staff and/or individual with the most direct knowledge is part of the report. Provider agencies may use GER reporting for events that are not required at their discretion. When using the GER to report such events, the report must have a modification level that must be low, be entered and approved within two business days of the event. Events that are tracked for internal agency purposes and do not meet reporting requirements per DD Waiver Service Standards must be marked with a notification level of "Low" to indicate that it is being used internal to the provider agency. **Appendix B GER Requirements**	care for neck abscess (Urgent Care). No GER was found. • Documentation reviewed indicates on 11/21/2023 the Individual went to urgent care for a seizure (Urgent Care). No GER was found.		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
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 # 1A05 General Requirements / Agency Policy and Procedure Requirements	**Condition of Participation Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 16 Qualified Provider Agencies:** Qualified DD Waiver Provider Agencies must deliver DD Waiver services. DD Waiver Provider Agencies must have a current Provider Agreement and continually meet required screening, licensure, accreditation, and training requirements as well as continually adhere to the DD Waiver Service Standards and relevant NMAC All Provider Agencies must comply with contract management activities to include any type of quality assurance review and/or compliance review completed by DDSD, the Division of Health Improvement (DHI) or other state agencies. **16.7 Compliance with Federal and State Rules and DD Waiver Service Standards** DD Waiver Provider agencies must comply with all applicable federal and state rules and DD Waiver Service Standards. Agencies are required to submit polices or procedural descriptions in their initial and renewal application which address applicable requirements. **16.7.1 Exception to the Standards:** In extraordinary circumstances, a Provider Agency may need to request an exception to the standards. An exception may be based on individual circumstances or extenuating circumstances at the agency. Any exception to	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interviews, the Agency did not develop, implement and / or comply with written policies and procedures to protect the physical / mental health of individuals that complies with all DDSD requirements. **When DSP were asked, what is the agency's on-call process, how on-call works, and How long does it take them to respond to you if you call the following was reported:** • DSP #632 stated, "They didn't give me that information. … does the monthly visits, I always call her and ask her about questions." (Individual #3) • DSP #681 stated, "1-877-782-8637. I don't actually know. I believe it is a nurse that is supposed to be at that number." (Individual #20) • DSP #504 stated, "Well a lot of times it's through texting, she doesn't call me back but through texting it's several hours before she'll get back to me but if I need to go speak to her I can get into my car and go see her." (Individual #30)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

the standards needs prior approval from DDSD… **STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 39. POLICIES AND REGULATIONS** Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD. Additionally, the PROVIDER agrees to abide by all the following, whenever relevant to the delivery of services specified under this Provider Agreement: a. DD, MF and Supports Waiver Service Standards. b. DEPARTMENT/DDSD Accreditation Mandate Policies. c. Policies and Procedures for Centralized Admission and Discharge Process for New Mexicans with Disabilities. d. Policies for Behavior Support Service Provisions. e. Rights of Individuals with Developmental Disabilities living in the Community, 7.26.3 NMAC. f. Service Plans for Individuals with Developmental Disability Community Programs, 7.26.5 NMAC. g. Requirement for Developmental Disability Community Programs, 7.26.6 NMAC. h. DEPARTMENT Client Complaint Procedures, 7.26.4 NMAC. i. Individual Transition Planning Process, 7.26.7 NMAC. j. Dispute Resolution Process, 7.26.8 NMAC. k. DEPARTMENT/DDSD Training Policies and Procedures. l. Fair Labor Standards Act. m. New Mexico Nursing Practice Act and New Mexico Board of Nursing requirements			

governing certified medication aides and administration of medications, 16.12.5 NMAC. n. Abuse, Neglect, Exploitation, and Death Reporting, Training and Related Requirements for Community Providers, 7.1.14 NMAC, and DHI/DEPARTMENT Incident Management System Policies and Procedures. o. DHI/DEPARTMENT Statewide Mortality Review Policy and Procedures. p. Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. q. Quality Management System and Review Requirements for Providers of Community Based Services, 7.14.2 NMAC. r. All Medicaid Regulations of the Medical Assistance Division of the HS D. s. Health Insurance Portability and Accountability Act (HIPAA). t. DEPARTMENT Sanctions Policy. u. All other regulations, standards, policies and procedures, guidelines and interpretive memoranda of the DDSD and the DHI of the DEPARTMENT.			

Tag #1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 3 Safeguards: 3.1 Decisions about Health Care or Other Treatment: Decision Consultation Process:** There are a variety of approaches and available resources to support decision making when desired by the person. The decision consultation process assists 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. **3.1.1 Decision about Health Care or Other Treatment Decision Consultation:** Decisions are the sole domain of waiver participants; their guardians or healthcare decision makers and decisions can be made that are compatible with their personal and cultural values. Provider Agencies and Interdisciplinary Teams (IDTs) are required to support the informed decisions made by supporting access to medical consultation, information, and other available resources according to the following: The Decision Consultation Process (DCP) is documented on the Decision Consultation Form (DCF) and is used for recommendations when a person or his/her guardian/healthcare decision maker has concerns, needs more information, or has decided not to follow all or part of a recommendation from a professional or clinician… **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records**	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review and interview, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 16 of 31 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Annual Physical:** • Not Found (#8, 11, 26, 30) **Annual Physical *(LCA Only)*:** • Not Found (#6, 13, 14, 29) **Annual Dental Exam:** • Individual #6 - As indicated by collateral documentation reviewed, the exam was not found. Per the Appendix A Client File matrix, Dental Exams are to be conducted annually. • Individual #8 - As indicated by collateral documentation reviewed, the exam was not found. Per the Appendix A Client File matrix, Dental Exams are to be conducted annually. • Individual #9 - As indicated by collateral documentation reviewed, the exam was not found. Per the Appendix A Client File matrix, Dental Exams are to be conducted annually.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. 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. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. 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. 6. 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.	• Individual #11 - As indicated by collateral documentation reviewed, the exam was not found. Per the Appendix A Client File matrix, Dental Exams are to be conducted annually. • Individual #12 - As indicated by collateral documentation reviewed, the exam was not found. Per the Appendix A Client File matrix, Dental Exams are to be conducted annually. • Individual #14 - As indicated by collateral documentation reviewed, the exam was not found. Per the Appendix A Client File matrix, Dental Exams are to be conducted annually. • Individual #15 - As indicated by collateral documentation reviewed, the exam was not found. Per the Appendix A Client File matrix, Dental Exams are to be conducted annually. • Individual #16 - As indicated by collateral documentation reviewed, the exam was completed on 6/20/2022. Per the Appendix A Client File matrix, Dental Exams are to be conducted annually. No evidence of current exam was found. • Individual #17 - As indicated by collateral documentation reviewed, the exam was not found. Per the Appendix A Client File matrix, Dental Exams are to be conducted annually. • Individual #21 - As indicated by collateral documentation reviewed, the exam was not found. Per the Appendix A Client File		

7. 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. 8. All records must be retained for six (6) years and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **20.5 Communication and Documentation in Therap:** Therap is a secure online documentation system required to be used by specific New Mexico DD Waiver Provider Agencies. Use of the required elements of Therap are intended to improve agency monitoring, health care coordination for individuals, and overall quality of services. **20.5.3 *Health Passport and Consultation Form:*** The Health Passport and Consultation form are generated within Therap. The standardized combination of documents includes all information that are required for medical consultation during an appointment and other health coordination activities: 1. The Primary Provider must keep the Health Passport and Consultation form updated in concert with critical information and changes from the IDT, including secondary provider agencies, medical providers for the individual. The Health Passport pulls from Individual Demographics, Health Tracking and eCHAT. a. The primary provider must notify secondary providers when a new eCHAT is completed or contact information is updated. 2. The Primary and Secondary Provider Agencies must ensure that a current copy of the *Health Passport* and *Consultation* forms are printed and available at all service delivery	matrix, Dental Exams are to be conducted annually. **Annual Physical:** • Individual #22 - As indicated by collateral documentation reviewed, Annual Physical was completed on 8/29/2023. Follow-up was to be completed in 4 months. No evidence of follow-up found. **Orthopedic Exam:** • Individual #10 - As indicated by collateral documentation reviewed, the exam was completed on 4/17/2023. No evidence of exam results was found. **Podiatry:** • Individual #2 - As indicated by collateral documentation reviewed, exam was completed on 4/6/2023. Follow-up was to be completed in 2 months. No evidence of follow-up found. **Primary Care:** • Individual #22 - As indicated by collateral documentation reviewed, visit was completed on 10/31/2023. Follow-up was to be completed in 1 month for Insomnia. No evidence of follow-up found.		

sites. a. Updated forms must be sent to each site after eCHAT and/or Contact Updates. b. Outdated version of both unused forms must be removed from all sites. 3. Primary and Secondary Provider Agencies must assure that the current *Health Passport* and *Consultation* form accompany each person when taken by the provider to a medical appointment, urgent care/emergency room visits, emergency service encounter, or are admitted to a hospital or nursing home for details see Health Tracking: Appointments **20.5.4 *Health Tracking*** **20.5.5 *Nursing Assessment Tracking*** **Chapter 13 Nursing Services: 13.2.3 General Requirements Related to Orders, Implementation, and Oversight:** 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. 2. Orders from licensed healthcare providers are implemented promptly and carried out until discontinued. a. The nurse will contact the ordering or on call practitioner as soon as possible 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. b. Not implementing orders by a licensed healthcare provider is considered neglect, unless a Decision Consultation Form is filled out by participant or guardian, or a healthcare decision maker making this decision.			

c. Based on prudent nursing practice, if a nurse determines to hold a practitioner's 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. d. 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.			

Tag # 1A09 Medication Delivery Routine Medication Administration *(Upheld by IRF)*	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 10 Living Care Arrangements (LCA): 10.3.5 Medication Assessment and Delivery:** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training; 2. the nursing and DSP functions identified in the Chapter 13.3 Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20 5.7 Medication Administration Record (MAR) **Chapter 20 Provider Documentation and Client Records: 20.5.7 Medication Administration Record (MAR):** Administration of medications apply to all provider agencies of the following services: living supports, customized community supports, community integrated employment, intensive medical living supports. 1. Primary and secondary provider agencies are to utilize the Medication Administration Record (MAR) online in Therap. 2. Medication/Treatment must be recorded online per assisting with medication delivery per the DDSD Assisting with Medication Delivery (AWMD) program. 3. Family Living Providers may opt not to use MARs if they are the **sole** provider who supports the person and are related by affinity or consanguinity. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, a MAR online in Therap must be created and used by the DSP.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of December 2023 and January 2024. Based on record review, 2 of 11 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #2 December 2023 As indicated by the Medication Administration Records the individual is to take Chlorpromazine 100mg (3 times daily). According to the Physician's Orders, Chlorpromazine 100mg is to be taken 2 times daily. Medication Administration Record and Physician's Orders do not match. Individual #9 December 2023 As indicated by the Medication Administration Records the individual is to take Calcium 600 mg (1 time daily). According to the Physician's Orders, Calcium Carbonate Antacid 500 mg is to be taken 3 times daily. Medication Administration Record and Physician's Orders do not match. *(Finding for Individual #9 is Upheld by IRF, no other finding was disputed)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

4. Provider Agencies must configure and use the MAR when assisting with medication. 5. Provider Agencies Continually communicate any changes about medications and treatments between Provider Agencies to assure health and safety. 6. Provider agencies must include the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed. b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine and PRN medications and other treatments; all over the counter (OTC) or "comfort" medications or treatments; all self-selected herbal preparation approved by the prescriber, and/or vitamin therapy approved by prescriber. c. Documentation of all time limited or discontinued medications or treatments. d. The initials of the person administering or assisting with medication delivery. e. Documentation of refused, missed, or held medications or treatments. f. Documentation of any allergic reaction that occurred due to medication or treatments. g. For PRN medications or treatments including all physician approved over the counter medications and herbal or other supplements: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear follow-up detailed documentation that the DSP contacted the agency nurse			

or physician service prior to assisting with the medication or treatment; and iii. documentation of the effectiveness of the PRN medication or treatment. **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and			

➢ the exact amount to be used in a 24-hour period.			

Tag # 1A09.1 Medication Delivery PRN Medication Administration *(Upheld by IRF)*	**Condition of Participation Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 10 Living Care Arrangements (LCA): 10.3.5 Medication Assessment and Delivery:** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training; 2. the nursing and DSP functions identified in the Chapter 13.3 Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20 5.7 Medication Administration Record (MAR) **Chapter 20 Provider Documentation and Client Records: 20.5.7 Medication Administration Record (MAR):** Administration of medications apply to all provider agencies of the following services: living supports, customized community supports, community integrated employment, intensive medical living supports. 1. Primary and secondary provider agencies are to utilize the Medication Administration Record (MAR) online in Therap. 2. Medication/Treatment must be recorded online per assisting with medication delivery per the DDSD Assisting with Medication Delivery (AWMD) program. 3. Family Living Providers may opt not to use MARs if they are the **sole** provider who supports the person and are related by affinity or consanguinity. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, a MAR online in Therap must be created and used by the DSP.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of December 2023 and January 2024 Based on record review, 4 of 11 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #9 December 2023 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Ibuprofen 200 mg (PRN) • Maalox or Mylanta 10 ml (PRN) • Benadryl 25 mg (PRN) • Robitussin DM 10 ml (PRN) Individual #17 January 2024 As indicated by the Medication Administration Record the individual is to take the following medication. The following medications were not in the Individual's home. • Milk of Magnesia 30 mL (PRN) • Nayzilam 5mg/spray (PRN) • Triple Antibiotic Ointment (PRN)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

4. Provider Agencies must configure and use the MAR when assisting with medication. 5. Provider Agencies Continually communicate any changes about medications and treatments between Provider Agencies to assure health and safety. 6. Provider agencies must include the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed. b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine and PRN medications and other treatments; all over the counter (OTC) or "comfort" medications or treatments; all self-selected herbal preparation approved by the prescriber, and/or vitamin therapy approved by prescriber. c. Documentation of all time limited or discontinued medications or treatments. d. The initials of the person administering or assisting with medication delivery. e. Documentation of refused, missed, or held medications or treatments. f. Documentation of any allergic reaction that occurred due to medication or treatments. g. For PRN medications or treatments including all physician approved over the counter medications and herbal or other supplements: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear follow-up detailed documentation that the DSP contacted the agency nurse	Individual #19 January 2024 As indicated by the Medication Administration Record the individual is to take the following medication. The following medications were not in the Individual's home. • Dextromethorphan HBR/Guaifenesin 1ml (PRN) • Diphenhydramine 25 mg (PRN) • Magnesium Hydroxide 30ml (PRN) • Phenylephrine 10 mg (PRN) • Polyethylene Glycol 17gm (PRN) • Triple Antibiotic Ointment (PRN) Individual #21 January 2024 As indicated by the Medication Administration Record the individual is to take the following medication. The following medications were not in the Individual's home. • Ibuprofen 200 mg (PRN) *(Findings for Individuals #9, 17, 19, 21 upheld by IRF)*		

or physician service prior to assisting with the medication or treatment; and iii. documentation of the effectiveness of the PRN medication or treatment. **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and			

➢ the exact amount to be used in a 24-hour period.			

Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 13 Nursing Services:** **13.3.2.3 Medication Oversight:** Medication Oversight by a DD Waiver nurse is required in Family Living when a person lives with a non-related Family Living provider; and whenever non-related DSP provide AWMD medication supports. 1. The nurse must respond to calls requesting delivery of PRN medications from AWMD trained DSP, non-related Family Living providers. 2. Family Living providers related by affinity or consanguinity (blood, adoption, or marriage) are not required to contact the nurse prior to assisting with delivery of a PRN medication. 3. Medication Oversight is optional if the person lives independently and can self-administer their medication or resides with their related family. If the person resides with their family and it is determined that Medication Oversight is not desired, the family must continue to provide any needed health supports or interventions based on guidance from the Primary Care Practitioner or specialists and all elements of medication administration and oversight are the sole responsibility of the person and their biological family. In addition, for Family Living participants the related family must: a. Communicate as needed any change of condition with the agency nurse. b. The agency is not responsible for providing a monthly MAR unless the family requests it and continually communicates all medication changes to the Provider Agency in a timely manner to ensure accuracy of the MAR.	Based on record review, the Agency did not maintain documentation of PRN authorization as required by standard for 1 of 11 Individuals. Individual #26 December 2023 No documentation of the verbal authorization from the Agency nurse prior to each administration / assistance of PRN medication was found for the following PRN medication: • Robitussin DM – PRN – 12/30 (given 2 times)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

4. Medication Oversight is not optional if substitute care is provided by DSP who are not related. a. A MAR is required for the substitute care provider to use. b. Biological families (by affinity or consanguinity) are encouraged, but not required to use the MAR. c. DSP who are related families (by affinity or consanguinity) must complete AWMD training.			

Tag # 1A27.0 Immediate Action and Safety Plan *(Modified by IRF)*	Standard Level Deficiency		
NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS: C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications: **(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall: **(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable; **(b)** be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and **(c)** provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057. Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 18: Incident Management System:** **18.3 Immediate Action and Safety Plans (IASP):** Upon discovery of any alleged incident of ANE, the DD Waiver Provider Agency shall: 1. develop an Immediate Action and Safety Plans (IASP) for potentially endangered individuals; 2. be immediately prepared to report the IASP verbally to the DHI during the reporting of the initial allegation;	Based on record review, the Agency did not develop an Immediate Action and Safety Plans (IASP) for potentially endangered individuals and / or submit it to the Case Manager for 3 of 31 Individuals. The following ANE reports had no evidence of an IASP being completed and / or sent to the case manager: Individual #2 • Incident date 11/13/2023 (6:00 AM). Type of incident identified was neglect. No IASP found. Individual #9 • Incident date 11/13/2023 (6:00 AM). Type of incident identified was neglect. No IASP found. Individual #24 • Incident date 11/23/2023 (3:00 PM). Type of incident identified was neglect. No IASP found. Individual #26 • Incident date 11/13/2023 (6:00 AM). Type of incident identified was neglect. No IASP found. *(Finding for #24 will be removed as Ability First was not the responsible provider. Findings for #2, 9, 26 will be upheld by IRF)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

3. report the IASP in writing on the DHI- issued IASP form within 24 hours; 4. revise the plan according to the DHI's direction, if necessary; 5. Send the IASP to the Case Manager; 6. closely follow and not change or deviate from the accepted IASP, without approval from the DHI.			

Tag #1A31 Client Rights / Human Rights	Condition of Participation Level Deficiency		
NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 2 Human Rights:** Civil rights apply to everyone including all waiver participants. Everyone including family members, guardians, advocates, natural supports, and Provider Agencies have a responsibility to make sure the rights of persons receiving services are not violated. All Provider Agencies play a role in person-centered planning (PCP)	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review the Agency did not ensure the rights of Individuals was not restricted or limited for 3 of 5 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. <u>No documentation</u> was found regarding Human Rights Approval for the following: • Use of 911 - No evidence found of Human Rights Committee approval. (Individual #11) • Psychotropic Medications to control behaviors - No evidence found of Human Rights Committee approval. (Individual #15) • Use of 911 & Crisis Intervention Team - No evidence found of Human Rights Committee approval. (Individual #17)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

and have an obligation to contribute to the planning process, always focusing on how to best support the person and protecting their human and civil rights. ***2.2*** **Home and Community Based Services (HCBS): Consumer Rights and Freedom:** People with I/DD receiving DD Waiver services, have the same basic legal, civil, and human rights and responsibilities as anyone else. Rights shall never be limited or restricted unnecessarily, without due process and the ability to challenge the decision, even if a person has a guardian. Rights should be honored within any assistance, support, and services received by the person.. **Chapter 3 Safeguards: 3.4.5 Interventions Requiring HRC Review and Approval:** HRCs must review any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies that include a restriction of an individual's rights; this HRC should occur prior to implementation of the strategy or strategies proposed. Categories requiring an HRC review include, but are not limited to, the following: 1. response cost (See the BBS Guidelines for Using Response Cost); 2. restitution (See BBS Guidelines for Using Restitution); 3. emergency physical restraint (EPR); 4. routine use of law enforcement as part of a BCIP; 5. routine use of emergency hospitalization procedures as part of a BCIP; 6. use of point systems; 7. use of intense, highly structured, and specialized treatment strategies, including levels systems with response cost or failure to earn components; 8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons;			

9. use of PRN psychotropic medications; 10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand); 11. use of bed rails; 12. use of a device and/or monitoring system through RPST may impact the person's privacy or other rights; or 13. use of any alarms to alert staff to a person's whereabouts.			

Tag # 1A31.2 Human Right Committee Composition	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 3 Safeguards: 3.4 *Human Rights Committee:*** Human Rights Committees (HRC) exist to protect the rights and freedoms of all waiver participants through the review of proposed restrictions to a person's rights based on a documented health and safety concern of a severe nature (e.g., a serious, significant, credible threat or act of harm against self, others, or property). HRCs monitor the implementation of certain time-limited restrictive interventions designed to protect a waiver participant and/or the community from harm. An HRC may also serve other functions as appropriate, such as the review of agency policies on the use of emergency physical restraint or sexuality if desired. HRCs are required for all Living Supports (Supported Living, Family Living, Intensive Medical Living Services), Customized Community Supports (CCS) and Community Integrated Employment (CIE) Provider Agencies. 1. HRC membership must include: a. at least one member with a diagnosis of I/DD; b. a parent or guardian of a person with I/DD; c. a health care services professional (e.g., a physician or nurse); and d. a member from the community at large that is not directly associated (currently or within the past three (3) years) with DD Waiver services.	Based on record review, the Agency did not ensure the correct composition of the human rights committee. **Review of Agency's HRC committee found the following were not members of the HRC:** • *at least one member with a diagnosis of I/DD.* • *a member from the community at large that is not associated (past or present) with DD Waiver services.* **When asked if the Agency had a Human Rights Committee consisting of all required members, the following was reported:** • #767 stated, "We had an individual at one point but no longer have one as we have not found anyone to replace her and the other HRC members are our HR Admins, and two of our Directors at Ability".	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A33 Board of Pharmacy: Med. Storage	Standard Level Deficiency		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **E. Medication Storage:** 1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee. 2. Drugs to be taken by mouth will be separate from all other dosage forms. 3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature. 4. Separate compartments are required for each resident's medication. 5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day. 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist. **8. References** A. Adequate drug references shall be available for facility staff **H. Controlled Substances (Perpetual Count Requirement)** 1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance, indicating the following information: a. date b. time administered	Based on observation, the Agency did not ensure proper storage of medication for 8 of 23 individuals. Observation included: Separate compartments were NOT kept for each individual living in the home. (Individual #2, 4, 9, 16, 17, 19, 25, 26) *Note: The following Individuals share a residence:* • #2, 9, 26 • #4, 17 • #21, 22	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

c. name of patient d. dose e. practitioner's name f. signature of person administering or assisting with the administration the dose g. balance of controlled substance remaining. **NMAC 16.19.11 DRUG CONTROL** **(a)** All state and federal laws relating to storage, administration and disposal of controlled substances and dangerous drugs shall be complied with. **(b)** Separate sheets shall be maintained for controlled substances records indicating the following information for each type and strength of controlled substances: date, time administered, name of patient, dose, physician's name, signature of person administering dose, and balance of controlled substance in the container. **(c)** All drugs shall be stored in locked cabinets, locked drug rooms, or state of the art locked medication carts. **(d)** Medication requiring refrigeration shall be kept in a secure locked area of the refrigerator or in the locked drug room. **(e)** All refrigerated medications will be kept in separate refrigerator or compartment from food items. **(f)** Medications for each patient shall be kept and stored in their originally received containers, and stored in separate compartments. Transfer between containers is forbidden, waiver shall be allowed for oversize containers and controlled substances at the discretion of the drug inspector. **(g)** Prescription medications for external use shall be kept in a locked cabinet separate from other medications. **(h)** No drug samples shall be stocked in the licensed facility. **(i)** All drugs shall be properly labeled with the following information:			

(i) Patient's full name; **(ii)** Physician's name; **(iii)** Name, address and phone number of pharmacy; **(iv)** Prescription number; **(v)** Name of the drug and quantity; **(vi)** Strength of drug and quantity; **(vii)** Directions for use, route of administration; **(viii)** Date of prescription (date of refill in case of a prescription renewal); **(ix)** Expiration date where applicable: The dispenser shall place on the label a suitable beyond-use date to limit the patient's use of the medication. Such beyond-use date shall be not later than (a) the expiration date on the manufacturer's container, or (b) one year from the date the drug is dispensed, whichever is earlier; **(x)** Auxiliary labels where applicable; **(xi)** The Manufacturer's name; **(xii)** State of the art drug delivery systems using unit of use packaging require items i and ii above, provided that any additional information is readily available at the nursing station. Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 10 Living Care Arrangement (LCA):** **10.3.7 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: … 8. 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; …			

Tag # LS06 Family Living Requirements	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 10 Living Care Arrangements (LCA) Living Supports Family Living:** **10.3.9.2.1 Monitoring and Supervision:** Family Living Provider Agencies must: 1. Provide and document monthly face-to-face consultation in the Family Living home conducted by agency supervisors or internal service coordinators with the DSP and the person receiving services to include: a. reviewing implementation of the person's ISP, Outcomes, Action Plans, and associated support plans, including HCPs, Health Passport, PBSP, CARMP, Therapy Plans, WDSI; b. scheduling of activities and appointments and advising the DSP regarding expectations and next steps, including the need for IST or retraining from a nurse, nutritionist, therapists or BSC; and c. assisting with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator, or other IDT members. 2. Monitor that the DSP implement and document progress of the AT inventory, Remote Personal Support Technology (RPST), physician and nurse practitioner orders, therapy, HCPs, PBSP, BCIP, PPMP, RMP, and CARMPs… **10.3.9.2.1.1 Home Study:** An on-site Home Study is required to be conducted by the Family Living Provider agency initially, annually, and if there are any changes in the home location, household makeup, or other significant event.	Based on record review, the Agency did not complete all DDSD requirements for approval of each direct support provider for 3 of 12 individuals. Review of the Agency files revealed the following items were not found, incomplete, and/or not current: **Monthly Consultation with the Direct Support Provider and the person receiving services:** • Individual #3 - None found for 2/2023. • Individual #14 - None found for 10/2023. • Individual #20 - None found for 1/2023 and 6/2023.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)	Standard Level Deficiency		

Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023
Chapter 10 Living Care Arrangement (LCA): 10.3.7 Requirements for Each Residence (SL, FL, IMLS): Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence:
1. has basic utilities, i.e., gas, power, water, telephone, and internet access;
2. promotes a safe environment free of any abuse, neglect, and exploitation;
3. supports telehealth, and/ or family/friend contact on various platforms or using various devices;
4. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher;
5. has a general-purpose first aid kit;
6. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift;
7. has water temperature that does not exceed a safe temperature (1100 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;
8. 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;
9. has an emergency placement plan for relocation of people in the event of an
	Based on record review and observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 7 of 19 Living Care Arrangement residences.
	
	Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:
	
	Supported Living Requirements:
	
	• Water temperature in home exceeds safe temperature (110^0 F):
	  • Water temperature in home measured 131.5^0 F (#2, 9, 26)
	  • Water temperature in home measured 116.4^0 F (#3)
	  • Water temperature in home measured 127^0 F (#4,17)
	  • Water temperature in home measured 117^0 F (#5)
	  • Water temperature in home measured 122^0 F (#6, 15)
	  • Water temperature in home measured 114^0 F (#21, 22)
	  • Water temperature in home measured 137^0 F (#24)
	
	Note: The following Individuals share a residence:
	• #2, 9, 26
		Provider:
		State your Plan of Correction for the deficiencies cited in this tag here *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: →
		
		Provider:
		Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

emergency evacuation that makes the residence unsuitable for occupancy; 10. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 11. 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; 12. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed; 13. has the phone number for poison control within line of site of the telephone; 14. has general household appliances, and kitchen and dining utensils; 15. has proper food storage and cleaning supplies; 16. has adequate food for three meals a day and individual preferences; 17. has at least two bathrooms for residences with more than two residents; 18. 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; and 19. has Personal Protective Equipment available, when needed. **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. 3. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the	• #4, 17 • #21, 22		

Therap web-based system using computers or mobile devices are acceptable. **20.3 Record Access for Direct Support Professional (DSP) during Service Delivery:** DSP must have access to records, plans, and forms needed to adequately provide and document the type of service and specific scope of service being provided at the time.			

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 # IS25 Community Integrated Employment Services	**Standard Level Deficiency**		
NMAC 8.302.2 Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 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… **21.4 Electronic Visit Verification:**	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Community Integrated Employment Services for 1 of 3 individuals Individual #31 October 2023 • The Agency billed 40 units of Community Integrated Employment Services (T2019 HB UA) on 10/26/2023. Documentation received accounted for 32 units. November 2023 • The Agency billed 40 units of Community Integrated Employment Services (T2019 HB UA) on 11/9/2023. Documentation received accounted for 32 units.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

Section 12006(a) of the 21st Century Cures Act (the Cures Act) requires that states implement Electronic Visit Verification (EVV) for all Medicaid services under the umbrella of personal care and home health care that require an in-home visit by a provider. The EVV system verifies the: a. **Type** of service performed. b. **Individual receiving** the service. c. **Date** of service. d. **Location** of service delivery. e. **Individual providing** the service. f. **Time** the service begins and ends. **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 where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. **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: 1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2. 2. Services that last in their entirety less than eight minutes cannot be billed.			

Tag # IS30 Customized Community Supports Reimbursement	Standard Level Deficiency		
NMAC 8.302.2 Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 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… **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.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports services for 5 of 13 individuals. Individual #7 October 2023 • The Agency billed 62 units of Customized Community Supports (T2021 HB U9) on 10/26/2023. Documentation received accounted for 32 units. Individual #8 October 2023 • The Agency billed 13 units of Customized Community Supports (H2021 HB U1) on 10/4/2023. Documentation did not contain the required element(s) on 10/4/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 52 units of Customized Community Supports (H2021 HB U1) on 10/5/2023. Documentation did not contain the required element(s) on 10/5/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 17 units of Customized Community Supports (H2021 HB U1) on 10/9/2023. Documentation did not contain the required element(s) on 10/9/2023. Documentation received accounted for 0 units as services were provided concurrently with another service.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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 where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. **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: 1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2. 2. Services that last in their entirety less than eight minutes cannot be billed.	• The Agency billed 14 units of Customized Community Supports (H2021 HB U1) on 10/10/2023. Documentation did not contain the required element(s) on 10/10/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 44 units of Customized Community Supports (H2021 HB U1) on 10/11/2023. Documentation did not contain the required element(s) on 10/11/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 26 units of Customized Community Supports (H2021 HB U1) on 10/12/2023. Documentation did not contain the required element(s) on 10/12/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 33 units of Customized Community Supports (H2021 HB U1) on 10/13/2023. Documentation did not contain the required element(s) on 10/13/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 13 units of Customized Community Supports (H2021 HB U1) on 10/16/2023. Documentation did not contain the required element(s) on 10/16/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 38 units of Customized Community Supports (H2021 HB U1) on		

	10/19/2023. Documentation did not contain the required element(s) on 10/19/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 44 units of Customized Community Supports (H2021 HB U1) on 10/20/2023. Documentation did not contain the required element(s) on 10/20/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 27 units of Customized Community Supports (H2021 HB U1) on 10/24/2023. Documentation did not contain the required element(s) on 10/24/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 33 units of Customized Community Supports (H2021 HB U1) on 10/25/2023. Documentation did not contain the required element(s) on 10/25/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 35 units of Customized Community Supports (H2021 HB U1) on 10/26/2023. Documentation did not contain the required element(s) on 10/26/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 10/27/2023. Documentation did not contain the required element(s) on		

	10/27/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 10/27/2023. Documentation did not contain the required element(s) on 10/27/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 23 units of Customized Community Supports (H2021 HB U1) on 10/30/2023. Documentation did not contain the required element(s) on 10/30/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. November 2023 • The Agency billed 44 units of Customized Community Supports (H2021 HB U1) on 11/2/2023. Documentation did not contain the required element(s) on 11/2/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 11/3/2023. Documentation did not contain the required element(s) on 11/3/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 44 units of Customized Community Supports (H2021 HB U1) on 11/7/2023. Documentation did not contain the required element(s) on 11/7/2023. Documentation received accounted for 0		

	units as services were provided concurrently with another service. • The Agency billed 33 units of Customized Community Supports (H2021 HB U1) on 11/8/2023. Documentation did not contain the required element(s) on 11/8/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 55 units of Customized Community Supports (H2021 HB U1) on 11/9/2023. Documentation did not contain the required element(s) on 11/9/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 22 units of Customized Community Supports (H2021 HB U1) on 11/13/2023. Documentation did not contain the required element(s) on 11/13/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 26 units of Customized Community Supports (H2021 HB U1) on 11/16/2023. Documentation did not contain the required element(s) on 11/16/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 35 units of Customized Community Supports (H2021 HB U1) on 11/21/2023. Documentation did not contain the required element(s) on 11/21/2023. Documentation received accounted for 0 units as services were provided concurrently with another service.		

	• The Agency billed 12 units of Customized Community Supports (H2021 HB U1) on 11/24/2023. Documentation did not contain the required element(s) on 11/24/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 11/29/2023. Documentation did not contain the required element(s) on 11/29/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 20 units of Customized Community Supports (H2021 HB U1) on 11/30/2023. Documentation did not contain the required element(s) on 11/30/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. December 2023 • The Agency billed 36 units of Customized Community Supports (H2021 HB U1) on 12/1/2023. Documentation did not contain the required element(s) on 12/1/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 17 units of Customized Community Supports (H2021 HB U1) on 12/4/2023. Documentation did not contain the required element(s) on 12/4/2023. Documentation received accounted for 0 units as services were provided concurrently with another service.		

	• The Agency billed 14 units of Customized Community Supports (H2021 HB U1) on 12/5/2023. Documentation did not contain the required element(s) on 12/5/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 12/6/2023. Documentation did not contain the required element(s) on 12/6/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 12 units of Customized Community Supports (H2021 HB U1) on 12/11/2023. Documentation did not contain the required element(s) on 12/11/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 29 units of Customized Community Supports (H2021 HB U1) on 12/14/2023. Documentation did not contain the required element(s) on 12/14/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 33 units of Customized Community Supports (H2021 HB U1) on 12/20/2023. Documentation did not contain the required element(s) on 12/20/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 19 units of Customized Community Supports (H2021 HB U1) on		

	12/21/2023. Documentation did not contain the required element(s) on 12/21/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 23 units of Customized Community Supports (H2021 HB U1) on 12/23/2023. Documentation did not contain the required element(s) on 12/23/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 32 units of Customized Community Supports (H2021 HB U1) on 12/25/2023. Documentation did not contain the required element(s) on 12/25/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 19 units of Customized Community Supports (H2021 HB U1) on 12/26/2023. Documentation did not contain the required element(s) on 12/26/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 31 units of Customized Community Supports (H2021 HB U1) on 12/27/2023. Documentation did not contain the required element(s) on 12/27/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. Individual #11 October 2023 • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on		

	10/13/2023. Documentation did not contain the required element(s) on 10/13/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 24 units of Customized Community Supports (H2021 HB U1) on 10/16/2023. Documentation did not contain the required element(s) on 10/16/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 22 units of Customized Community Supports (H2021 HB U1) on 10/18/2023. Documentation did not contain the required element(s) on 10/18/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. November 2023 • The Agency billed 17 units of Customized Community Supports (H2021 HB U1) on 11/2/2023. Documentation did not contain the required element(s) on 11/2/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 22 units of Customized Community Supports (H2021 HB U1) on 11/9/2023. Documentation did not contain the required element(s) on 11/9/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 20 units of Customized Community Supports (H2021 HB U1) on 11/14/2023. Documentation did not		

	contain the required element(s) on 11/14/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 21 units of Customized Community Supports (H2021 HB U1) on 11/15/2023. Documentation did not contain the required element(s) on 11/15/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 22 units of Customized Community Supports (H2021 HB U1) on 11/16/2023. Documentation did not contain the required element(s) on 11/16/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 25 units of Customized Community Supports (H2021 HB U1) on 11/21/2023. Documentation did not contain the required element(s) on 11/21/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 27 units of Customized Community Supports (H2021 HB U1) on 11/28/2023. Documentation did not contain the required element(s) on 11/28/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 22 units of Customized Community Supports (H2021 HB U1) on 11/29/2023. Documentation did not contain the required element(s) on 11/29/2023. Documentation received		

	accounted for 0 units as services were provided concurrently with another service. • The Agency billed 19 units of Customized Community Supports (H2021 HB U1) on 11/30/2023. Documentation did not contain the required element(s) on 11/30/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. Individual #17 October 2023 • The Agency billed 11 units of Customized Community Supports (H2021 HB U1) on 10/5/2023. Documentation did not contain the required element(s) on 10/5/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 36 units of Customized Community Supports (H2021 HB U1) on 10/30/2023. Documentation received accounted for 25 units. November 2023 • The Agency billed 4 units of Customized Community Supports (H2021 HB U1) on 11/3/2023. Documentation did not contain the required element(s) on 11/3/2023. Documentation received accounted for 0 units. The required element(s) were not met: • A description of what occurred during the encounter or service interval. • The Agency billed 12 units of Customized Community Supports (H2021 HB U1) on 11/27/2023. Documentation did not contain the required element(s) on 11/27/2023. Documentation received accounted for 0		

	units. The required element(s) were not met: • A description of what occurred during the encounter or service interval. December 2023 • The Agency billed 13 units of Customized Community Supports (H2021 HB U1) on 12/6/2023. Documentation did not contain the required element(s) on 12/6/2023. Documentation received accounted for 0 units. The required element(s) were not met: • A description of what occurred during the encounter or service interval. • The Agency billed 4 units of Customized Community Supports (H2021 HB U1) on 12/8/2023. Documentation did not contain the required element(s) on 12/8/2023. Documentation received accounted for 0 units. The required element(s) were not met: • A description of what occurred during the encounter or service interval. • The Agency billed 15 units of Customized Community Supports (H2021 HB U1) on 12/22/2023. Documentation did not contain the required element(s) on 12/22/2023. Documentation received accounted for 0 units. The required element(s) were not met: • A description of what occurred during the encounter or service interval. • The Agency billed 32 units of Customized Community Supports (H2021 HB U1) on 12/27/2023. Documentation received accounted for 15 units. Individual #19		

	November 2023 • The Agency billed 28 units of Customized Community Supports (H2021 HB U1) on 11/4/2023. Documentation did not contain the required element(s) on 11/4/2023. Documentation received accounted for 27 units as services were provided concurrently with another service. • The Agency billed 48 units of Customized Community Supports (H2021 HB U1) on 11/25/2023. Documentation did not contain the required element(s) on 11/25/2023. Documentation received accounted for 47 units as services were provided concurrently with another service. December 2023 • The Agency billed 16 units of Customized Community Supports (H2021 HB U1) on 12/4/2023. Documentation did not contain the required element(s) on 12/4/2023. Documentation received accounted for 14 units as services were provided concurrently with another service. • The Agency billed 16 units of Customized Community Supports (H2021 HB U1) on 12/15/2023. Documentation did not contain the required element(s) on 12/15/2023. Documentation received accounted for 0 units as services were provided concurrently with another service. • The Agency billed 40 units of Customized Community Supports (H2021 HB U1) on 12/17/2023. Documentation did not contain the required element(s) on 12/17/2023. Documentation received accounted for 36 units as services were provided concurrently with another service.		

Tag # LS26 Supported Living Reimbursement	Standard Level Deficiency		
NMAC 8.302.2 Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 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… **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.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 1 of 11 individuals. Individual #16 October 2023 • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 10/18/2023. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount. November 2023 • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 11/4/2023. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 10.75 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 11/7/2023. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 11.5 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 11/12/2023.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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 where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. **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: 1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2. 2. Services that last in their entirety less than eight minutes cannot be billed.	Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 2 hours, which is less than the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 11/13/2023. Documentation received accounted for .5 units. As indicated by the DDW Standards at least 12 hours in a 24 hour period must be provided in order to bill a complete unit. Documentation received accounted for 10 hours, which is less than the required amount.		

Tag # LS27 Family Living Reimbursement	Standard Level Deficiency		
NMAC 8.302.2 Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 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… **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.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Family Living Services for 1 of 12 individuals. Individual #20 December 2023 • The Agency billed 1 unit of Family Living (T2033 HB) on 12/6/2023. Documentation received accounted for 0 units. *(Note: Progress note indicated the Individual was "out of program")* • The Agency billed 1 unit of Family Living (T2033 HB) on 12/7/2023. *(Note: Progress note indicated the Individual was "out of program")*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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 where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. **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: 1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2. 2. Services that last in their entirety less than eight minutes cannot be billed.			

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date: April 11, 2024

To: Chelsey Hester, Operations Director

Provider: Ability First, LLC
Address: 2610 San Mateo Blvd. NE, Suite A
State/Zip: Albuquerque, New Mexico 87110

E-mail Address: chester@arizonaautism.com

CC: rsherman@arizonaautism.com

Region: Metro
Survey Date: January 22 – February 2, 2024

Program Surveyed: Developmental Disabilities Waiver

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

Survey Type: Routine

Dear Ms. Hester:

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

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

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

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

If the Verification survey identifies repeat deficiencies, the Plan of Correction process will continue, and your case may be referred to the Internal Review Committee for discussion of possible civil monetary penalties possible monetary fines and/or other sanctions.

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

Sincerely,

Marie Passaglia, BA

Marie Passaglia, BA
Healthcare Surveyor Advanced/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.FY24.3.DDW.24883310.5.001.RTN.07.24.102