Date: November 13, 2012

To: Ed Kaul, President/Chief Executive Officer
Provider: ARCA
Address: 11300 Lomas NE
State/Zip: Albuquerque, New Mexico 87112

E-mail Address: ekaul@arc-a.org

Region: Metro
Routine Survey: April 2 - 11, 2012
Verification Survey: October 30 – November 1, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living, Family Living & Independent Living) & Community Inclusion Supports (Adult Habilitation, Community Access & Supported Employment)
Survey Type: Verification
Team Leader: Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Kaul;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on February 6 – 9, 2012*.

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

Compliance with Conditions of Participation

However due to the new/repeat deficiencies your report of findings will be referred to the Internal Review Committee (IRC) for further action and potential sanctions. You will be contacted by the IRC for instructions on how to proceed. Please call the Plan of Correction Coordinator at 505-699-9356, if you have questions about the survey or the report.

Thank you for your cooperation and for the work you perform.

Sincerely,

Jennifer Bruns, BSW

Jennifer Bruns, BSW
Team Lead/Healthcare Surveyor
Division of Health Improvement/Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	October 30, 2012	
Present:	**ARCA** Ed Kaul, President/Chief Executive Officer **DOH/DHI/QMB** Jennifer Bruns, BSW, Team Leader/Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor	
Exit Conference Date:	November 1, 2012	
Present:	**ARCA** Ed Kaul, President/Chief Executive Officer Naomi Serna-Olander, Human Resources Coordinator Sharon Hannah, Case Record Manager Michelle Harmon, Service Director **DOH/DHI/QMB** Jennifer Bruns, BSW, Team Leader/Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor	
Total Homes Visited	Number:	38
❖ Supported Homes Visited	Number:	20
❖ Family Homes Visited	Number:	18
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	47 5 - *Jackson* Class Members 42 - Non-*Jackson* Class Members 18 - Supported Living 18 - Family Living 11 - Independent Living 24 - Adult Habilitation 3 - Community Access 18 - Supported Employment
Persons Served Records Reviewed	Number:	47
Direct Support Personnel Interviewed	Number:	45
Direct Support Personnel Records Reviewed	Number:	315
Service Coordinator Records Reviewed	Number:	25
Administrative Files Reviewed	• Billing Records • Medical Records • Incident Management Records • Personnel Files • Training Records	

- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes
- Evacuation Drills
- Quality Assurance / Improvement Plan

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

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 state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; 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 Management system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on the provider's compliance or non-compliance with standards and regulations identified in the QMB Report of Findings. 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.

Within the QMB Service Domains there are fundamental regulations, standards, or policies with which a provider must be in essential compliance in order to ensure the health and welfare of individuals served known as Conditions of Participation (CoPs).

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in three (3) Service Domains.

Case Management Services:

- Level of Care,
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

- Qualified Provider,
- Plan of Care,
- Health, Welfare & Safety

Conditions of Participation (CoPs)

A CoP is an identified fundamental regulation, standard, or policy with which a provider must be in compliance in order to ensure the health and welfare of individuals served. CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances. A provider must be in compliance with CoPs to participate as a waiver provider.

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP. (See the next section for a list of CoPs.) The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

CoPs and Service Domains for Case Management Supports are as follows:

Service Domain: Level of Care

Condition of Participation:

1. **Level of Care**: The Case Manager shall complete all required elements of the Long Term Care Assessment Abstract (LTCAA) to ensure ongoing eligibility for waiver services.

Condition Level Tag:

- Tag 4C04 Allocation Activities

Service Domain: Plan of Care

Condition of Participation:

2. **Individual Service Plan (ISP) Creation and Development**: Each individual shall have an ISP. The ISP shall be developed in accordance with DDSD regulations and standards and is updated at least annually or when warranted by changes in the individual's needs.

Condition Level Tags:

- Tag 4C07 ISP Development
- Tag 4C08 ISP Development Process
- Tag 4C10 Approval (completion) of the MAD 046/Budget
- Tag 4C16 Requirements for reports and distribution of documents

Condition of Participation:

3. **ISP Monitoring and Evaluation:** The Case Manager shall ensure the health and welfare of the individual through monitoring the implementation of ISP desired outcomes.

Condition Level Tag:

- Tag 4C12 Monitoring and Evaluation of Services

CoPs and Service Domain for ALL Service Providers is as follows:

Service Domain: Qualified Providers

Condition of Participation:

4. **Qualified Providers**: Agencies shall ensure support staff has completed criminal background screening and all mandated trainings as required by the DDSD.

Condition Level Tags:

a. (General requirements for all providers)

- Tag 1A20 DDSD Required Trainings (if <84% compliant)
- Tag 1A22 Qualifications (Competency) for All Staff
- Tag 1A25 Caregivers Criminal History Screening
- Tag 1A26 COR Consolidated Online Registry Check (Employee Abuse Registry)
- Tag 1A36 Qualifications for Service Coordinators
- Tag 1A37 Individual Specific Trainings and Competency for Direct Service Personnel and Service Coordinators
- Tag 4C17 Qualifications for Case Managers
- Tag 6L06 Home Study Assessment. (Family Living only)

CoPs and Service Domains for Living Supports and Inclusion Supports are as follows:

Service Domain: Plan of Care

Condition of Participation:

5. **ISP Implementation**: Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

Condition level Tags:

- Tag 1A32/6L14 Implementation of the ISP

Service Domain: Health, Welfare & Safety

Condition of Participation:

6. **Individual Health, Safety and Welfare: (Safety)** Individuals have the right to live and work in a safe environment.

Condition level Tags:

a. **(Environmental)** Individuals shall live and work in healthy and safe environments.
   - Tag 1A05 Health and Safety Related Policies and Procedures
   - Tag 1A16 Sanitation (Environmental Health and Safety)
   - Tag 6L25 Residential Requirement (Environmental Requirements)

b. **(Human Rights)**: Individuals shall be afforded their basic human rights.
   - Tag 1A31 Restriction of Rights

Condition of Participation:

7. **Individual Health, Safety and Welfare (Healthcare Oversight)**: The provider shall support individuals to access needed healthcare services in a timely manner. Nursing, healthcare services and healthcare oversight shall be available and provided as needed to address individuals' health, safety and welfare.

Condition level Tags:

- Tag 6L13/1A08 Healthcare Maintenance, Monitoring and Follow-up
- Tag 1A09 Medication Delivery
- Tag 1A15 Healthcare Oversight
- Tag 1A15.2/5I09 Healthcare Documentation

QMB Compliance Determinations

Compliance with Conditions of Participation

The QMB determination of *Compliance with Conditions of Participation* indicates that a provider is in compliance with all Conditions of Participation, (CoP). 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 with Conditions of Participation, the provider must be in compliance with all Conditions of Participation in all relevant Service Domains. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) out of compliance in any of the Service Domains.

Partial-Compliance with Conditions of Participation

The QMB determination of *Partial-Compliance with Conditions of Participation* indicates that a provider is out of compliance with Conditions of Participation in one (1) to two (2) Service Domains. The agency may have one or more Condition level tags within a Service Domain. 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. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains.

Providers receiving a repeat determination of Partial-Compliance for repeat deficiencies at the level of a Condition in any Service Domain may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

Non-Compliance with Conditions of Participation

The QMB determination of *Non-Compliance with Conditions of Participation* indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains. 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. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

Providers receiving a repeat determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

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 in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
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: http://dhi.health.state.nm.us/qmb
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 IRC process, email the IRF Chairperson, Scott Good at scott.good@state.nm.us for assistance.

The following limitations apply to the IRF process:

- The 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 made 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.

Agency: **ARCA - Metro Region**
Program: Developmental Disabilities Waiver
Service: Community Living Supports (Supported Living, Family Living & Independent Living) & Community Inclusion Supports (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Verification Survey
Routine Survey: **April 2 - 11, 2012**
Verification Survey: **October 30 – November 1, 2012**

Standard of Care	Deficiencies Cited During Routine Survey April 2 - 11, 2012	New and Repeat Deficiencies Cited During Verification Survey October 30 – November 1, 2012
CMS Assurance – 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 # 1A08.1 Agency Case File - Progress Notes	**Standard Level Deficiency**	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the	Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 3 of 50 Individuals. **Adult Habilitation Progress Notes/Daily Contact Logs** • Individual #14 - None found for 12/2011 - 1/2012 • Individual #38 - None found for 12/2011 - 2/2012 • Individual #45 - None found for 12/2011 - 1/2012	**New/Repeat Findings:** Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 1 of 47 Individuals. **Adult Habilitation Progress Notes/Daily Contact Logs** • Individual #14 - None found for 9/12/2012.

following requirements: (3) Progress notes and other service delivery documentation;		

Standard of Care	Deficiencies Cited During Routine Survey April 2 - 11, 2012	New and Repeat Deficiencies Cited During Verification Survey October 30 – November 1, 2012
CMS Assurance – Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A03 CQI System	N/A	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents		**New Finding:** Based on record review, the Agency failed to implement a Continuous Quality Management System. Review of the findings from the April 2 – 11, 2012 survey indicated the Agency had multiple deficiencies noted. During the verification survey the agency continues to have deficiencies which either were not corrected or sufficiently addressed since the last survey and as stated in the Plan of Correction.

leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:** **E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system: **(1)** community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements; **(2)** community based service providers providing developmental disabilities services must have a designated incident management coordinator in place; **(4)** community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified…		

Standard of Care	Deficiencies Cited During Routine Survey April 2 - 11, 2012	New and Repeat Deficiencies Cited During Verification Survey October 30 – November 1, 2012
CMS Assurance – Medicaid Billing/Reimbursement/Financial Accountability – *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 # 5I36 Community Access Reimbursement	**Standard Level Deficiency**	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 1 of 3 individuals. Individual #2 December 2011 • The Agency billed 218 units of Community Access (H2021 U1) from 12/1/2011 through 12/31/2011. Documentation received accounted for 162 units.	**New/Repeat Findings:** Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 2 of 3 individuals. Individual #2 September 2012 • The Agency billed 12 units of Community Access (H2021 U1) on 9/8/2012. Documentation received accounted for 8 units. • The Agency billed 14 units of Community Access (H2021 U1) on 9/10/2012. Documentation received accounted for 10 units. Individual #35 September 2012 • The Agency billed 19 units of Community Access (H2021 U1) on 09/21/2012. Documentation received accounted for 15 units.

fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS** **G. Reimbursement** (1) Billable Unit**:** A billable unit is defined as one-quarter hour of service. (2) Billable Activities**:** The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan; (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and (c) Non face-to-face hours do not exceed 10% of the monthly billable hours. (3) Non-Billable Activities**:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include: (a) Time and expense for training service personnel; (b) Supervision of agency staff; (c) Service documentation and billing activities; or		

(d) Time the individual spends in segregated facility-based settings activities.		

Tag # 5I44 Adult Habilitation Reimbursement	Standard Level Deficiency	Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 16 of 26 individuals. Individual #2 December 2011 • The Agency billed 189 units of Adult Habilitation (T2021 U2) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1, 8, 12, 13, 15, 19, 20, 22, 27 & 29. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval; Individual #5 December 2012 • The Agency billed 61 units of Adult Habilitation (T2021 U2) from 12/1/2011 through 12/31/2011. Documentation received accounted for 41 units. Individual #7 January 2012 • The Agency billed 550 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 466 units. Individual #8 January 2012 • The Agency billed 443 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 405 units. Individual #12	**New/Repeat Findings:** Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 3 of 24 individuals. Individual #14 September 2012 • The Agency billed 12 units of Adult Habilitation (T2021 U2) on 9/4/2012. Documentation did not contain the required elements on 9/4/2012. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval; • The Agency billed 12 units of Adult Habilitation (T2021 U2) on 9/6/2012. Documentation did not contain the required elements on 9/6/2012. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval; • The Agency billed 20 units of Adult Habilitation (T2021 U2) on 9/12/2012. Documentation did not contain the required elements on 9/12/2012. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ No documentation found. Individual #39 September 2012 • The Agency billed 22 units of Adult Habilitation (T2021 U2) on 9/17/2012. Documentation received accounted for 17 units.

Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care. **B. Billable Activities** (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non-face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours. (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours	January 2012 • The Agency billed 505 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 436 units. Individual #14 December 2011 • The Agency billed 119 units of Adult Habilitation (T2021 U2) 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1/2011 through 12/31/2011. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ No documentation found. January 2012 • The Agency billed 149 units of Adult Habilitation (T2021 U2) 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1/2011 through 12/31/2011. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ No documentation found. Individual #15 January 2012 • The Agency billed 172 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 149 units. Individual #27 December 2011 • The Agency billed 64 units of Adult Habilitation (T2021 U2) from 12/1/2011 through 12/31/2011. Documentation received accounted for 56 units.	Individual #43 September 2012 • The Agency billed 30 units of Adult Habilitation (T2021 U2) on 9/6/2012. Documentation did not contain the required elements on 9/6/2012. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval;

	February 2012 • The Agency billed 50 units of Adult Habilitation (T2021 U2) from 2/1/2012 through 2/29/2012. Documentation received accounted for 41 units. Individual #28 February 2012 • The Agency billed 76 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 2/29/2012. Documentation received accounted for 20 units. Individual #38 December 2011 • The Agency billed 380 units of Adult Habilitation (T2021 U2) 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1/2011 through 12/31/2011. Documentation received accounted for 0 units. One or more of the following elements was not met:. ➢ No documentation found. January 2012 • The Agency billed 432 units of Adult Habilitation (T2021 U2) 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/1/2012 through 1/31/2012. Documentation received accounted for 0 units. One or more of the following elements was not met:. ➢ No documentation found. February 2012 • The Agency billed 380 units of Adult Habilitation (T2021 U2) 2/1/2012 through 2/29/2012. Documentation did not contain the required elements on 2/1/2012 through 2/29/2012. Documentation received accounted for 0 units. One or more of the following elements was not met:	

	➢ No documentation found. Individual #41 January 2012 • The Agency billed 183 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 161 units. Individual #43 January 2012 • The Agency billed 202 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 170 units. February 2012 • The Agency billed 307 units of Adult Habilitation (T2021 U2) from 2/1/2012 through 2/29/2012. Documentation received accounted for 279 units. Individual #45 December 2011 • The Agency billed 440 units of Adult Habilitation (T2021 U2) 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1/2011 through 12/31/2011. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ No documentation found. January 2012 • The Agency billed 440 units of Adult Habilitation (T2021 U2) 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/1/2012 through 1/31/2012. Documentation received accounted for 0 units. One or more of the following elements was not	

	met: ➢ No documentation found. Individual #46 January 2012 • The Agency billed 262 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 219 units. Individual #48 January 2012 • The Agency billed 455 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 429 units. Individual #49 December 2011 • The Agency billed 394 units of Adult Habilitation (T2021 U2) from 12/1/2011 through 12/31/2011. Documentation received accounted for 320 units. January 2012 • The Agency billed 455 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 355 units.	

Tag # 6L27 Family Living Reimbursement	Standard Level Deficiency	Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 12 of 18 individuals. Individual #6 December 2011 • The Agency billed 31 units of Family Living (T2033) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/3, 4, 5, 10, 17, 18, 23, 25, 29 & 31. Documentation received accounted for 21 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. January 2012 • The Agency billed 31 units of Family Living (T2033) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/2, 3, 8, 14, 15, 21, 22, & 28. Documentation received accounted for 23 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. February 2012 • The Agency billed 29 units of Family Living (T2033) from 2/1/2012 through 2/29/2012. Documentation did not contain the required elements on 2/4, 5, 11, 12, 18, 19, 23, 25 & 28. Documentation received accounted for 20 units. One or more of the following elements was not met ➢ Date, start and end time of each service encounter or other billable service interval.	**New/Repeat Findings:** Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 6 of 18 individuals. Individual #7 September 2012 • The Agency billed 30 units of Family Living (T2033) from 9/1/2012 through 9/30/2012. Documentation did not contain the required elements on 9/5, 6, 7, 8, 10, 12, 13, 14, 16, 17, 19, 20, 21, 23, 24, 26, 27, 28, & 30. Documentation received accounted for 7 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. • The Agency billed 5 units of Family Living (T2033) on 9/1, 2, 3, 8 & 9. Documentation received accounted for 0 units. Documentation indicated that the individual "went home to visit." From documentation reviewed evidence indicated the Individual was not in the residence for any portion of the 24 hour period for each date listed above. Individual #8 September 2012 • The Agency billed 30 units of Family Living (T2033) from 9/1/2012 through 9/30/2012. Documentation received accounted for 0 units One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval;

Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES** B. Reimbursement for Family Living Services (1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year. (2) Billable Activities shall include: (a) Direct support provided to an individual in the residence any portion of the day; (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and (c) Any other activities provided in accordance with the Scope of Services. (3) Non-Billable Activities shall include: (a) The Family Living Services Provider Agency may not bill the for room and board; (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and (c) Family Living services may not be billed for the same time period as Respite. (d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **Chapter 6 - COMMUNITY LIVING SERVICES** **III. REQUIREMENTS UNIQUE TO FAMILY**	Individual #8 December 2011 • The Agency billed 31 units of Family Living (T2033) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/5, 13, 22, 23 & 26. Documentation received accounted for 26 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. January 2012 • The Agency billed 31 units of Family Living (T2033) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/15 & 29. Documentation received accounted for 29 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Individual #9 December 2011 • The Agency billed 31 units of Family Living (T2033) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/3, 10, 11, 13, 16, 17, 18, 23, 24, 25, 26, 30 & 31. Documentation received accounted for 18 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. January 2012 • The Agency billed 31 units of Family Living (T2033) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/1, 7, 8, 13, 14, 15, 16, 21, 22, 28,	➢ A description of what occurred during the encounter or service interval; Individual #19 September 2012 • The Agency billed 30 units of Family Living (T2033) from 9/1/2012 through 9/30/2012. Documentation received accounted for 0 units One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval; ➢ A description of what occurred during the encounter or service interval; Individual #27 September 2012 • The Agency billed 30 units of Family Living (T2033) from 9/1/2012 through 9/30/2012. Documentation did not contain the required elements on 9/2, 3, 5, 6, 7, 9, 10, 12, 13, 14, 16, 17, 19, 20, 21, 23, 24, 26, 27, 28, & 30. Documentation received accounted for 9 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval; ➢ A description of what occurred during the encounter or service interval; Individual #29 September 2012 • The Agency billed 30 units of Family Living (T2033) from 9/1/2012 through 9/30/2012. Documentation received accounted for 0 units One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval; ➢ A description of what occurred during the encounter or service interval;

LIVING SERVICES **C. Service Limitations**. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore, a specified deduction to the daily rate for Family Living shall be made for each unit of respite received. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **DEFINITIONS** **SUBSTITUTE CARE** means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider. **RESPITE** means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.	29 & 30. Documentation received accounted for 19 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. February 2012 • The Agency billed 29 units of Family Living (T2033) from 2/1/2012 through 2/29/2012. Documentation did not contain the required elements on 2/3, 11, 12, 18, 19, 20, 21, 25 & 26. Documentation received accounted for 20 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Individual #10 December 2011 • The Agency billed 31 units of Family Living (T2033) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/3, 4, 5, 10, 11, 17, 18, 23, 24, 25, 26, 30 & 31. Documentation received accounted for 21 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. January 2012 • The Agency billed 31 units of Family Living (T2033) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/1, 2, 8, 1, 14, 15, 16, 21, 22, 28 & 29. Documentation received accounted for 21 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. February 2012	Individual #39 September 2012 • The Agency billed 30 units of Family Living (T2033) from 9/1/2012 through 9/30/2012. Documentation received accounted for 0 units One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval; ➢ A description of what occurred during the encounter or service interval;

	• The Agency billed 29 units of Family Living (T2033) from 2/1/2012 through 2/29/2012. Documentation did not contain the required elements on 2/1, 4, 5, 11, 12, 18, 19, 20, 24, 25 & 26. Documentation received accounted for 18 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Individual #11 December 2011 • The Agency billed 31 units of Family Living (T2033) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/3, 7, 9, 11, 14, 16, 17, 18, 21, 23, 24, 25, 26, 27, 28, 29, 30 & 31. Documentation received accounted for 13 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. January 2012 • The Agency billed 31 units of Family Living (T2033) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/1, 4, 6, 7, 8, 11, 13, 14, 15, 18, 21, 22, 25, 27, 28, 29 & 31. Documentation received accounted for 13 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. February 2012 • The Agency billed 29 units of Family Living (T2033) from 2/1/2012 through 2/29/2012. Documentation did not contain the required elements on 2/2, 3, 4, 5, 8, 10, 11, 12, 15, 17, 18, 19, 22, 24, 25, 26 & 29. Documentation	

	received accounted for 12 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Individual #13 December 2011 • The Agency billed 31 units of Family Living (T2033) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. January 2012 • The Agency billed 31 units of Family Living (T2033) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/1, 7, 8, 14, 15, 16, 21, 22, 24 & 27, 28 & 29. Documentation received accounted for 19 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. February 2012 • The Agency billed 29 units of Family Living (T2033) from 2/1/2012 through 2/29/2012. Documentation did not contain the required elements on 2/4, 5, 11, 12, 15, 18, 19, 20, 22 & 25. Documentation received accounted for 19 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Individual #18	

	December 2011 • The Agency billed 31 units of Family Living (T2033) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/4, 6, 11 & 24. Documentation received accounted for 27 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. January 2012 • The Agency billed 31 units of Family Living (T2033) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/15, 18, 21 & 22. Documentation received accounted for 27 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Individual #25 December 2011 • The Agency billed 31 units of Family Living (T2033) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/24, 25 & 28. Documentation received accounted for 28 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. February 2012 • The Agency billed 29 units of Family Living (T2033) from 2/1/2012 through 2/29/2012. Documentation did not contain the required elements on 2/10, 11, 18 & 20. Documentation received accounted for 25 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval.	

	Individual #26 December 2011 • The Agency billed 31 units of Family Living (T2033) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 18, 19 22 & 25, 26 & 27. Documentation received accounted for 13 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. January 2012 • The Agency billed 31 units of Family Living (T2033) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31.. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. February 2012 • The Agency billed 29 units of Family Living (T2033) from 2/1/2012 through 2/29/2012. Documentation did not contain the required elements on 2/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24 , 25, 26, 27, 28 7 29. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval Individual #27 December 2011 • The Agency billed 31 units of Family Living	

	(T2033) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/3, 4, 5, 11, 12 & 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31. Documentation received accounted for 10 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. January 2012 • The Agency billed 31 units of Family Living (T2033) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/12, 3, 4, 6, 7, 8, 9, 10, 13, 14, 15, 16, 20, 21, 22, 23, 27, 28, 29 & 30. Documentation received accounted for 10 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. February 2012 • The Agency billed 29 units of Family Living (T2033) from 2/1/2012 through 2/29/2012. Documentation did not contain the required elements on 2/3, 4, 5, 6, 12, 13, 17, 18, 19, 20 , 24, 25, 26, 27 & 29. Documentation received accounted for 14 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Individual #29 December 2011 • The Agency billed 31 units of Family Living (T2033) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/3, 4, 5, 10, 11, 17, 18, 20, 24, 25, 26, 27, 28, 29, 30 & 31. Documentation received accounted for 15 units. One or more	

	of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. January 2012 • The Agency billed 31 units of Family Living (T2033) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/7, 8, 14, 15, 20, 21, 22, 23, 24, 25, 28. 29 & 30. Documentation received accounted for 18 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. February 2012 • The Agency billed 29 units of Family Living (T2033) from 2/1/2012 through 2/29/2012. Documentation did not contain the required elements on 2/4, 5, 11, 12, 18, 19, 25, 26 & 29. Documentation received accounted for 20 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. Individual #36 December 2011 • The Agency billed 31 units of Family Living (T2033) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/2, 6, 8, 12, 17, 19, 23, 25, 26, 29 & 30. Documentation received accounted for 19 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. January 2012 • The Agency billed 31 units of Family Living	

	(T2033) from 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/1, 2, 6, 9, 12, 13, 14, 16, 21, 28 & 30. Documentation received accounted for 21 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval. February 2012 • The Agency billed 29 units of Family Living (T2033) from 2/1/2012 through 2/29/2012. Documentation did not contain the required elements on 2/2, 3, 10, 11, 13, 15, 17, 20, 23 & 27. Documentation received accounted for 19 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval.	

Standard of Care	Deficiencies Cited During Routine Survey April 2 - 11, 2012	New and Repeat Deficiencies Cited During Verification Survey October 30 – November 1, 2012
CMS Assurance – Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A32 & 6L14 ISP Implementation	Standard Level Deficiency	Completed
Tag # 6L14 Residential Case File	Standard Level Deficiency	Completed
CMS Assurance – 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 # 1A11.1 Transportation Training	Standard Level Deficiency	Completed
Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency	Completed
Tag # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency	Completed
Tag # 1A25 Criminal Caregiver History Screening	Standard Level Deficiency	Completed
Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	Standard Level Deficiency	Completed
Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency	Completed
Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency	Completed
Tag # 1A36 Service Coordination Requirements	Standard Level Deficiency	Completed
Tag # 1A37 Individual Specific Training	Standard Level Deficiency	Completed
CMS Assurance – 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 # 1A09 Medication Delivery (MAR) - Routine Medication	Standard Level Deficiency	Completed

Tag # 1A09.1 Medication Delivery - PRN Medication	Standard Level Deficiency	Completed
Tag # 1A15.2 & 5I09 - Healthcare Documentation	Standard Level Deficiency	Completed
Tag # 1A27 Incident Mgt Late & Failure to Report	Standard Level Deficiency	Completed
Tag # 6L13 Community Living Healthcare Reqts.	Standard Level Deficiency	Completed
Tag # 6L25 Residential Health & Safety (Supported Living & Family Living)	Standard Level Deficiency	Completed
CMS Assurance – Financial Accountability – *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 # 5I25 Supported Employment Reimbursement	Standard Level Deficiency	Completed

Date: May 20, 2013

To: Ed Kaul, President/Chief Executive Officer
Provider: ARCA
Address: 11300 Lomas NE
State/Zip: Albuquerque, New Mexico 87112

E-mail Address: ekaul@arc-a.org

Region: Metro
Routine Survey Date: April 2 - 11, 2012
Verification Survey #1: October 30 – November 1, 2012
Verification Survey #2: April 18, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living, Family Living, Independent Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)
Survey Type: Verification
Team Leader: Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Kaul;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on February 6 – 9, 2012 and the Verification Survey on October 30 – November 1, 2012*.

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

Compliance with Conditions of Participation

However, due to the new/repeat deficiencies your report of findings will be referred to the Internal Review Committee (IRC) for further action and potential sanctions. You will be contacted by the IRC for instructions on how to proceed. Please call the Plan of Correction Coordinator at 505-699-9356, if you have questions about the survey or the report.

Thank you for your cooperation and for the work you perform.

Sincerely,

Jennifer Bruns, BSW

Jennifer Bruns, BSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	4/18/2013	
Present:	**ARCA** Michelle Harmon, Service Director **DOH/DHI/QMB** Jennifer Bruns, BSW, Team Leader/Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor	
Exit Conference Date:	4/18/2013	
Present:	**ARCA** Michelle Harmon, Service Director **DOH/DHI/QMB** Jennifer Bruns, BSW, Team Leader/Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor	
Administrative Locations Visited	Number:	1
Routine Survey Sample Size	Number:	53 5 - *Jackson* Class Members 48 - Non-*Jackson* Class Members 22 - Supported Living 20- Family Living 11 - Independent Living 28 - Adult Habilitation 3 - Community Access 18 - Supported Employment
Verification #2 Survey Sample Size	Number:	8 0 - *Jackson* Class Members 8 - Non-*Jackson* Class Members 4 - Supported Living 4 - Family Living 6 - Adult Habilitation

Administrative Files Reviewed

- Billing Records

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

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 state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; 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 Management 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 in the QMB Report of Findings. 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.

Within the QMB Service Domains there are fundamental regulations, standards, or policies with which a provider must be in essential compliance in order to ensure the health and welfare of individuals served known as Conditions of Participation (CoPs).

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in three (3) Service Domains.

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

- Qualified Provider
- Plan of Care
- Health, Welfare and Safety

Conditions of Participation (CoPs)

A CoP is an identified fundamental regulation, standard, or policy with which a provider must be in compliance in order to ensure the health and welfare of individuals served. CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances. A provider must be in compliance with CoPs to participate as a waiver provider.

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP. (See the next section for a list of CoPs.) The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

CoPs and Service Domains for Case Management Supports are as follows:

Service Domain: Level of Care

Condition of Participation:

5. **Level of Care**: The Case Manager shall complete all required elements of the Long Term Care Assessment Abstract (LTCAA) to ensure ongoing eligibility for waiver services.

Service Domain: Plan of Care

Condition of Participation:

6. **Individual Service Plan (ISP) Creation and Development**: Each individual shall have an ISP. The ISP shall be developed in accordance with DDSD regulations and standards and is updated at least annually or when warranted by changes in the individual's needs.

Condition of Participation:

7. **ISP Monitoring and Evaluation:** The Case Manager shall ensure the health and welfare of the individual through monitoring the implementation of ISP desired outcomes.

CoPs and Service Domain for ALL Service Providers is as follows:

Service Domain: Qualified Providers

Condition of Participation:

8. **Qualified Providers**: Agencies shall ensure support staff has completed criminal background screening and all mandated trainings as required by the DDSD.

CoPs and Service Domains for Living Supports and Inclusion Supports are as follows:

Service Domain: Plan of Care

Condition of Participation:

6. **ISP Implementation**: Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

Service Domain: Health, Welfare and Safety

Condition of Participation:

6. **Individual Health, Safety and Welfare: (Safety)** Individuals have the right to live and work in a safe environment.

Condition of Participation:

7. **Individual Health, Safety and Welfare (Healthcare Oversight)**: The provider shall support individuals to access needed healthcare services in a timely manner. Nursing, healthcare services and healthcare oversight shall be available and provided as needed to address individuals' health, safety and welfare.

QMB Determinations of Compliance

Compliance with Conditions of Participation

The QMB determination of *Compliance with Conditions of Participation* indicates that a provider is in compliance with all Conditions of Participation, (CoP). 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 with Conditions of Participation, the provider must be in compliance with all Conditions of Participation in all relevant Service Domains. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) out of compliance in any of the Service Domains.

Partial-Compliance with Conditions of Participation

The QMB determination of *Partial-Compliance with Conditions of Participation* indicates that a provider is out of compliance with Conditions of Participation in one (1) to two (2) Service Domains. The agency may have one or more Condition level tags within a Service Domain. 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. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains.

Providers receiving a repeat determination of Partial-Compliance for repeat deficiencies at the level of a Condition in any Service Domain may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

Non-Compliance with Conditions of Participation

The QMB determination of *Non-Compliance with Conditions of Participation* indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains. 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. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

Providers receiving a repeat determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

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 Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
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: http://dhi.health.state.nm.us/qmb
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 IRC process, email the IRF Chairperson, Scott Good at scott.good@state.nm.us for assistance.

The following limitations apply to the IRF process:

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

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

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

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

Agency: **ARCA - Metro Region**
Program: Developmental Disabilities Waiver
Service: Community Living Supports (Supported Living, Family Living, Independent Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)
Monitoring Type: Verification Survey
Routine Survey: **April 2 - 11, 2012**
Verification Survey #1: **October 30 – November 1, 2012**
Verification Survey #2: **April 18, 2013**

Standard of Care	Routine Survey April 2 - 11, 2012 Deficiencies	Verification Survey #1 October 30 – November 1, 2012 New and Repeat Deficiencies	Verification Survey #2 April 18, 2013 New and Repeat Deficiencies
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 # 1A08.1 Agency Case File - Progress Notes	**Standard Level Deficiency**	**Standard Level Deficiency**	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government	Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 3 of 50 Individuals. **Adult Habilitation Progress Notes/Daily Contact Logs** • Individual #14 - None found for 12/2011 - 1/2012 • Individual #38 - None found for 12/2011 - 2/2012 • Individual #45 - None found for 12/2011 - 1/2012	**New/Repeat Findings:** Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 1 of 47 Individuals. **Adult Habilitation Progress Notes/Daily Contact Logs** • Individual #14 - None found for 9/12/2012.	**New/Repeat Findings:** Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 1 of 8 Individuals. **Adult Habilitation Progress Notes/Daily Contact Logs** • Individual #61 - None found for 3/12-13, 2013.

representatives for oversight purposes. The individual's case file shall include the following requirements: (3) Progress notes and other service delivery documentation;			

Standard of Care	Routine Survey April 2 - 11, 2012 Deficiencies	Verification Survey #1 October 30 – November 1, 2012 New and Repeat Deficiencies	Verification Survey #2 April 18, 2013 New and Repeat Deficiencies
Service Domain: Medicaid Billing/Reimbursement/Financial Accountability – *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 # 5I44 Adult Habilitation Reimbursement	**Standard Level Deficiency**	**Standard Level Deficiency**	
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND**	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 16 of 26 individuals. Individual #2 December 2011 • The Agency billed 189 units of Adult Habilitation (T2021 U2) from 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1, 8, 12, 13, 15, 19, 20, 22, 27 & 29. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval; Individual #5 December 2012 • The Agency billed 61 units of Adult Habilitation (T2021 U2) from 12/1/2011 through 12/31/2011. Documentation received accounted for 41 units. Individual #7 January 2012 • The Agency billed 550 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted	**New/Repeat Findings:** Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 3 of 24 individuals. Individual #14 September 2012 • The Agency billed 12 units of Adult Habilitation (T2021 U2) on 9/4/2012. Documentation did not contain the required elements on 9/4/2012. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval; • The Agency billed 12 units of Adult Habilitation (T2021 U2) on 9/6/2012. Documentation did not contain the required elements on 9/6/2012. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval; • The Agency billed 20 units of Adult Habilitation (T2021 U2) on 9/12/2012. Documentation did not contain the required elements on 9/12/2012. Documentation received accounted for 0 units. One or more of the	**New/Repeat Findings:** Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 3 of 6 individuals. Individual #39 March 2013 • The Agency billed 43 units of Adult Habilitation (T2021 U3) on 3/29/2013. Documentation received accounted for 22 units. Individual #60 March 2013 • The Agency billed 243 units of Adult Habilitation (T2021 U2) on 3/18/2013. Documentation received accounted for 22 units. Individual #61 March 2013 • The Agency billed 19 units of Adult Habilitation (T2021 U1) on 3/12/2013. Documentation did not contain the required elements on 3/12/2013. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ No documentation found.

DOCUMENTATION REQUIREMENTS: Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care. **B. Billable Activities** (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours. (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours	for 466 units. Individual #8 January 2012 • The Agency billed 443 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 405 units. Individual #12 January 2012 • The Agency billed 505 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 436 units. Individual #14 December 2011 • The Agency billed 119 units of Adult Habilitation (T2021 U2) 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1/2011 through 12/31/2011. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ No documentation found. January 2012 • The Agency billed 149 units of Adult Habilitation (T2021 U2) 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1/2011 through 12/31/2011. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ No documentation found. Individual #15 January 2012 • The Agency billed 172 units of Adult	following elements was not met: ➢ No documentation found. Individual #39 September 2012 • The Agency billed 22 units of Adult Habilitation (T2021 U2) on 9/17/2012. Documentation received accounted for 17 units. Individual #43 September 2012 • The Agency billed 30 units of Adult Habilitation (T2021 U2) on 9/6/2012. Documentation did not contain the required elements on 9/6/2012. One or more of the following elements was not met: ➢ Date, start and end time of each service encounter or other billable service interval;	• The Agency billed 19 units of Adult Habilitation (T2021 U1) on 3/13/2013. Documentation did not contain the required elements on 3/13/2013. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ No documentation found.

	Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 149 units. Individual #27 December 2011 • The Agency billed 64 units of Adult Habilitation (T2021 U2) from 12/1/2011 through 12/31/2011. Documentation received accounted for 56 units. February 2012 • The Agency billed 50 units of Adult Habilitation (T2021 U2) from 2/1/2012 through 2/29/2012. Documentation received accounted for 41 units. Individual #28 February 2012 • The Agency billed 76 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 2/29/2012. Documentation received accounted for 20 units. Individual #38 December 2011 • The Agency billed 380 units of Adult Habilitation (T2021 U2) 12/1/2011 through 12/31/2011. Documentation did not contain the required elements on 12/1/2011 through 12/31/2011. Documentation received accounted for 0 units. One or more of the following elements was not met:. ➢ No documentation found. January 2012 • The Agency billed 432 units of Adult Habilitation (T2021 U2) 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/1/2012 through		

	1/31/2012. Documentation received accounted for 0 units. One or more of the following elements was not met:. ➢ No documentation found. February 2012 • The Agency billed 380 units of Adult Habilitation (T2021 U2) 2/1/2012 through 2/29/2012. Documentation did not contain the required elements on 2/1/2012 through 2/29/2012. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ No documentation found. Individual #41 January 2012 • The Agency billed 183 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 161 units. Individual #43 January 2012 • The Agency billed 202 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 170 units. February 2012 • The Agency billed 307 units of Adult Habilitation (T2021 U2) from 2/1/2012 through 2/29/2012. Documentation received accounted for 279 units. Individual #45 December 2011 • The Agency billed 440 units of Adult Habilitation (T2021 U2) 12/1/2011 through 12/31/2011. Documentation did not contain		

	the required elements on 12/1/2011 through 12/31/2011. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ No documentation found. January 2012 • The Agency billed 440 units of Adult Habilitation (T2021 U2) 1/1/2012 through 1/31/2012. Documentation did not contain the required elements on 1/1/2012 through 1/31/2012. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ No documentation found. Individual #46 January 2012 • The Agency billed 262 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 219 units. Individual #48 January 2012 • The Agency billed 455 units of Adult Habilitation (T2021 U2) from 1/1/2012 through 1/31/2012. Documentation received accounted for 429 units. Individual #49 December 2011 • The Agency billed 394 units of Adult Habilitation (T2021 U2) from 12/1/2011 through 12/31/2011. Documentation received accounted for 320 units. January 2012 • The Agency billed 455 units of Adult Habilitation (T2021 U2) from 1/1/2012 through		

	1/31/2012. Documentation received accounted for 355 units.		

Standard of Care	Routine Survey April 2 - 11, 2012 Deficiencies	Verification Survey #1 October 30 – November 1, 2012 New and Repeat Deficiencies	Verification Survey #2 April 18, 2013 New and Repeat Deficiencies
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A32 & 6L14 ISP Implementation	Standard Level Deficiency	Completed	NA
Tag # 6L14 Residential Case File	Standard Level Deficiency	Completed	NA
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 # 1A11.1 Transportation Training	Standard Level Deficiency	Completed	NA
Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency	Completed	NA
Tag # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency	Completed	NA
Tag # 1A25 Criminal Caregiver History Screening	Standard Level Deficiency	Completed	NA
Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	Standard Level Deficiency	Completed	NA
Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency	Completed	NA
Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency	Completed	NA
Tag # 1A36 Service Coordination Requirements	Standard Level Deficiency	Completed	NA
Tag # 1A37 Individual Specific Training	Standard Level Deficiency	Completed	NA
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A03 CQI System	NA	Standard Level Deficiency	NA
Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Standard Level Deficiency	Completed	NA

Tag # 1A09.1 Medication Delivery - PRN Medication	Standard Level Deficiency	Completed	NA
Tag # 1A15.2 & 5I09 - Healthcare Documentation	Standard Level Deficiency	Completed	NA
Tag # 1A27 Incident Mgt Late & Failure to Report	Standard Level Deficiency	Completed	NA
Tag # 6L13 Community Living Healthcare Reqts.	Standard Level Deficiency	Completed	NA
Tag # 6L25 Residential Health & Safety (Supported Living & Family Living)	Standard Level Deficiency	Completed	NA
Service Domain: Medicaid Billing/Reimbursement/Financial Accountability – *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 # 5I25 Supported Employment Reimbursement	Standard Level Deficiency	Completed	NA
Tag # 5I36 Community Access Reimbursement	Standard Level Deficiency	Standard Level Deficiency	Completed
Tag # 6L27 Family Living Reimbursement	Standard Level Deficiency	Standard Level Deficiency	Completed

Date: June 18, 2013

To: Ed Kaul, President/Chief Executive Officer
Provider: ARCA
Address: 11300 Lomas NE
State/Zip: Albuquerque, New Mexico 87112
E-mail Address: ekaul@arc-a.org

Region: Metro
Routine Survey: April 2 - 11, 2012
Verification #1: October 30 – November 1, 2012
Verification #2: April 18, 2013
Program Surveyed: Developmental Disabilities Waiver
Survey Type: Verification

RE: Request for an Informal Reconsideration of Findings

Dear Mr. Kaul;

Your request for a Reconsideration of Findings was received on May 23, 2013. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A08.1
Determination: The IRF committee is removing the original finding in the report of findings.

Regarding Tag # 5I44
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated for Individual #39. Based on documentation supplied the citation for billing/reimbursement for Individual #61 for March 12 & 13, 2013 will be removed. The citation for billing/reimbursement for Individual #60 for March 18, 2013 will also be removed.

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

Thank you.
Respectfully,

Scott Good
Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

Date: July 09, 2013

To: Ed Kaul, President/Chief Executive Officer
Provider: ARCA
Address: 11300 Lomas NE
State/Zip: Albuquerque, New Mexico 87112

E-mail Address: ekaul@arc-a.org

Region: Metro
Routine Survey Date: April 2 - 11, 2012
Verification Survey #1: October 30 – November 1, 2012
Verification Survey #2: April 18, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living, Family Living, Independent Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)
Survey Type: Verification

Dear Mr. Kaul;

You have completed all the requirements per the Internal Review Committee (IRC).

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Crystal Lopez-Beck
Plan of Correction Coordinator
Quality Management Bureau/DHI