Dear Mr. Perez;

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

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

**Partial Compliance with Conditions of Participation**

This determination is based on non-compliance with one or more CMS waiver assurances at the Condition of Participation level as well as Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.
Plan of Correction:
The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency’s compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the receipt of this letter.

Submission of your Plan of Correction:
Please submit your agency’s Plan of Correction in the space on the two right columns of the Report of Findings. (See attachment “A” for additional guidance in completing the Plan of Correction).

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

1. Quality Management Bureau, Attention: Plan of Correction Coordinator
   5301 Central Ave. NE Suite 400 Albuquerque, NM 87108

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

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

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

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

   QMB Deputy Bureau Chief
   5301 Central Ave NE Suite #400
   Albuquerque, NM  87108
   Attention: IRF request

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

Please call the Plan of Correction Coordinator at 505-699-9356 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Tony Fragua, BFA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau
**Survey Process Employed:**

**Survey Process Employed:**

**Entrance Conference Date:** September 16, 2013

**Present:**
- **Bright Horizons, Inc.**
  - Ignacio Perez, Executive Director
  - Jason McDermott, Owner
- **DOH/DHI/QMB**
  - Tony Fragua, BFA, Team Lead/Healthcare Surveyor
  - Erica Nilsen, BA, Healthcare Surveyor
  - Meg Pell, BA, Healthcare Surveyor
  - Nadine Romero, Healthcare Surveyor
  - Cynthia Nielsen, MSN, RN, Healthcare Surveyor

**Exit Conference Date:** September 19, 2013

**Present:**
- **Bright Horizons, Inc.**
  - Ignacio Perez, Executive Director
  - Tina Rantanen, RN
  - Frankie Tellez, Program Manager
- **DOH/DHI/QMB**
  - Tony Fragua, BFA, Team Lead/Healthcare Surveyor
  - Nadine Romero, LBSW, Healthcare Surveyor
  - Cynthia Nielsen, MSN, RN, Healthcare Surveyor
  - Meg Pell, BA, Healthcare Surveyor
  - Erica Nilsen, BA, Healthcare Surveyor

**Administrative Locations Visited**
- Number: 1

**Total Sample Size**
- Number: 12
  - 1 - Jackson Class Members
  - 11 - Non-Jackson Class Members
  - 8 - Supported Living
  - 3 - Family Living
  - 7 - Adult Habilitation
  - 3 - Community Access

**Total Homes Visited**
- Number: 8
  - Supported Living Homes Visited Number: 6
  - Family Living Homes Visited Number: 2

**Persons Served Records Reviewed**
- Number: 12

**Persons Served Interviewed**
- Number: 9

**Persons Served Observed**
- Number: 3 (3 Individuals were not available during on-site visits)

**Direct Support Personnel Interviewed**
- Number: 16

**Direct Support Personnel Records Reviewed**
- Number: 89
Substitute Care/Respite Personnel
Records Reviewed Number: 6

Service Coordinator Records Reviewed Number: 4

Administrative Processes and Records Reviewed:

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

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
IRC – Internal Review Committee
Attachment A

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

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

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

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

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

If you have questions about the Plan of Correction process, call the QMB Deputy Chief/Plan of Correction Coordinator at 505-222-8650 or email at Crystal.Lopez-Beck@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

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

Instructions for Completing Agency POC:

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

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

The Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and

QMB Report of Findings – Bright Horizons, Inc. – Metro Region – September 16 - 20, 2013
Survey Report #: Q.14.1-DDW.D2079.5.001.RTN.01.316
Page 5 of 68
sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and

5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.

6. The POC must be signed and dated by the agency director or other authorized official.

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

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the QMB Deputy Chief/POC Coordinator, Crystal Lopez-Beck at 505-222-8650 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Crystal Lopez-Beck, Deputy Chief/POC Coordinator in any of the following ways:
   a. Electronically at Crystal.Lopez-Beck@state.nm.us (preferred method)
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Avenue NE, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”
   a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45
      business days from the date of receipt of your Report of Findings to correct all survey
      deficiencies.
   b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45
      business day limit is in effect.
   c. If your POC is denied a second time your agency may be referred to the Internal Review
      Committee.
   d. You will receive written confirmation when your POC has been approved by QMB and a final
      deadline for completion of your POC.
   e. Please note that all POC correspondence will be sent electronically unless otherwise
      requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will
   result in a referral to the Internal Review Committee and the possible implementation of monetary
   penalties and/or sanctions.

**POC Document Submission Requirements**

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

1. Your internal documents are due within a **maximum** of 45 business days of receipt of your Report of
   Findings.
2. You may submit your documents by postal mail (paper hard copy or on a disc), fax, or electronically
   (scanned and attached to e-mails).
3. All submitted documents **must be annotated**: please be sure the tag numbers and Identification
   numbers are indicated on each document submitted. Documents which are not annotated with the Tag
   number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence.
   Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate
   cited deficiencies have been corrected, other attestations of correction must be approved by the Plan
   of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and
   adjust forms submitted to Xerox State Healthcare, LLC. for the deficiencies cited in the Report of
   Findings. In addition to this, we ask that you submit:
   a. Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals
      and timeframes of your choosing to verify POC implementation;
   b. Copies of “void and adjust” forms submitted to Xerox State Healthcare, LLC. to correct all
      unjustified units identified and submitted for payment during your internal audit.

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

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

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and 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:
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.

**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 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.

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.

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.

**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 IRF process, email the IRF Chairperson, Crystal Lopez-Beck at crystal.lopez-beck@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:** Bright Horizons, Inc. - Metro Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Living Supports (Supported Living and Family Living) and Community Inclusion Supports (Adult Habilitation and Community Access)  
**Monitoring Type:** Routine Survey  
**Survey Date:** September 16 – 20, 2013

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Domain: Service Plans: ISP Implementation</strong></td>
<td><strong>Service Domain: Service Plans: ISP Implementation</strong> – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tag # 1A08 Agency Case File</strong></td>
<td><strong>Standard Level Deficiency</strong></td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
</tbody>
</table>


**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 following requirements:

1. Emergency contact information, including the

Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 7 of 12 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:

- ISP Signature Page (#4, 9, 13)
- Positive Behavioral Crisis Plan (#7)
- Speech Therapy Plan (#5, 9)
- Occupational Therapy Plan (#8)
- Dental Exam
  - Individual #12 - As indicated by collateral documentation reviewed, an exam was completed on 7/05/2011. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found.

**Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
| (1) | The individual’s address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician’s name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; |
| (2) | The individual’s complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); |
| (3) | Progress notes and other service delivery documentation; |
| (4) | Crisis Prevention/Intervention Plans, if there are any for the individual; |
| (5) | A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; |
| (6) | When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and |
| (7) | Case records belong to the individual receiving services and copies shall be provided to the individual upon request. |
| (8) | The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: |
| (a) | Complete file for the past 12 months; |
| (b) | ISP and quarterly reports from the current and prior ISP year; |
| (c) | Intake information from original admission to services; and |
| (d) | When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital. |
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
<table>
<thead>
<tr>
<th>Tag # 1A32 and 6L14 Individual Service Plan Implementation</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</td>
<td>Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan for 4 of 12 individuals.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</td>
<td>Per Individuals' ISP the following was found with regards to the implementation of ISP Outcomes:</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>D. The intent is to provide choice and obtain</td>
<td>Administrative Files Reviewed:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
<td></td>
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<tr>
<td></td>
<td>Individual #7</td>
<td></td>
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<td></td>
<td>• None found regarding: Live Outcome &quot;… will complete the book my Future Listography by September 2013&quot; for 5/2013 – 6/2013.</td>
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<tr>
<td></td>
<td>• None found regarding: Live Outcome “... will learn 6 new self-care skills by September 2013” for 5/2013 – 6/2013.</td>
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<tr>
<td></td>
<td>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
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<td></td>
<td>Individual #7</td>
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<tr>
<td></td>
<td>• Work/Learn Outcome; Action Step for “… will enter her allowance and expenditures is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/2013 – 6/21013.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residential Files Reviewed:</td>
<td></td>
</tr>
</tbody>
</table>
opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities.

[05/03/94; 01/15/97; Recompiled 10/31/01]

<table>
<thead>
<tr>
<th>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual #3</td>
</tr>
<tr>
<td>• Per Live Outcome; Action Step for “… will create a list of questions and possible solutions to her concerns,” is to be completed weekly. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/1 – 14, 2013.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual # 5</td>
</tr>
<tr>
<td>• None found regarding: Live Outcome; Action Step; “… will help to gather items needed for the meal” for 9/1 – 18, 2013.</td>
</tr>
<tr>
<td>• None found regarding Live Outcome; Action Step; “… will complete tasks to help complete the meal” for 9/1 – 18, 2013.</td>
</tr>
</tbody>
</table>

<p>| Individual #6                                                                         |
| None found for 9/1 – 18, 2013. |</p>
<table>
<thead>
<tr>
<th>Tag # 6L14</th>
<th>Residential Case File</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Residential Case File</strong></td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 8 of 11 Individuals receiving Family Living Services and/or Supported Living Services.</td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</strong></td>
<td>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A. Residence Case File:</strong></td>
<td>Current Emergency and Personal Identification Information</td>
<td>Did not contain Pharmacy Information (#10)</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td></td>
<td>Positive Behavioral Plan (#10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive Behavioral Crisis Plan (#6, 10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speech Therapy Plan (#4, 5, 6, 9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy Plan (#10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical Therapy Plan (#4, 10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Special Health Care Needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comprehensive Aspiration Risk Management Plan (#8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meal Time Plan (#5)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Nutritional Plan (#13)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Health Care Plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiac (#3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seizures (#13)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Emergency Response Plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aspiration (#5, 10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seizures (#13)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;

(7) Physician’s or qualified health care providers written orders;

(8) Progress notes documenting implementation of a physician’s or qualified health care provider’s order(s);

(9) Medication Administration Record (MAR) for the past three (3) months which includes:
   (a) The name of the individual;
   (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;
   (c) Diagnosis for which the medication is prescribed;
   (d) Dosage, frequency and method/route of delivery;
   (e) Times and dates of delivery;
   (f) Initials of person administering or assisting with medication; and
   (g) An explanation of any medication irregularity, allergic reaction or adverse effect.

(h) For PRN medication an explanation for the use of the PRN must include:
   (i) Observable signs/symptoms or circumstances in which the medication is to be used, and
   (ii) Documentation of the effectiveness/result of the PRN delivered.

(i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual’s home and an updated

• Progress Notes/Daily Contacts Logs:
  ◦ Individual #5 - None found for 9/1 – 18, 2013.
  ◦ Individual #6 - None found for 9/1 – 18, 2013.
copy must be placed in the agency file on a weekly basis.

(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and

(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.
<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Domain: Qualified Providers</strong> – 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.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Tag # 1A11.1 Transportation Training</strong></td>
<td><strong>Standard Level Deficiency</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 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… | Based on record review, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 1 of 89 Direct Support Personnel. **No documented evidence was found of the following required training:**  
- Transportation (DSP #92) | **Provider:**  
State your Plan of Correction for the deficiencies cited in this tag here: → | |

**Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date:** March 1, 2007 **II. POLICY STATEMENTS:**  
I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:  
1. Operating a fire extinguisher  
2. Proper lifting procedures  
3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver’s seat)  
4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines

Provider:  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff’s role)
6. Wheelchair tie-down procedures (if applicable to the staff’s role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)
<table>
<thead>
<tr>
<th>Tag # 1A20</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Support Personnel Training</td>
<td>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 12 of 89 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>• Pre-Service (DSP #117)</td>
</tr>
<tr>
<td>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td></td>
</tr>
<tr>
<td>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</td>
<td></td>
</tr>
<tr>
<td>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</td>
<td></td>
</tr>
<tr>
<td>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</td>
<td></td>
</tr>
<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for</td>
<td></td>
</tr>
</tbody>
</table>

**Provider:**
State your Plan of Correction for the deficiencies cited in this tag here: →

**Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →


**Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:**

A. Individuals shall receive services from competent and qualified staff.

B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.

C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.

D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.

E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.

F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.

G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.

H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.

I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.
<table>
<thead>
<tr>
<th>Tag # 1A22</th>
<th>Agency Personnel Competency</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td></td>
<td>Based on interview, the Agency did not ensure training competencies were met for 3 of 17 Direct Support Personnel.</td>
</tr>
<tr>
<td>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td>When DSP were asked if the individual had a Positive Behavioral Crisis Plan and if so, what the plan covered, the following was reported:</td>
<td></td>
</tr>
<tr>
<td>F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the</td>
<td>• DSP #61 stated, “I don’t believe she has a crisis plan.” According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #7)</td>
<td></td>
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<td></td>
<td>When DSP were asked if the Individual had a Physical Therapy Plan and if so, what the plan covered, the following was reported:</td>
<td></td>
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<tr>
<td></td>
<td>• DSP #88 stated, “I’m not sure, yes, but I haven’t seen the PT. I’m not sure what they work on.” According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• DSP #88 stated, “No.” As indicated by the Agency Case file, the Individual has Health Care Plans for Body Mass Index and as indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Oral Care. (Individual #4)</td>
<td></td>
</tr>
<tr>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here:</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</td>
<td></td>
</tr>
</tbody>
</table>
qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and

Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.

(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:

(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;

(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and

(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.

Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff.

- DSP #61 stated, “No.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Oral Hygiene, Body Mass Index and Aspiration. (Individual #7)

When DSP were asked if the Individual had any Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:

- DSP #61 stated, “I don’t believe she has a MERP.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plan for Aspiration. (Individual #7)

- DSP #73 stated, “No.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Seizures. (Individual #13)

When DSP were asked what the individual's Diagnosis were, the following was reported:

- DSP #61 stated, “Mild MR.” According to the individual's Agency Case File she is diagnosed with Depression, Impulse Control Disorder, Intermittent Explosive Disorder Obesity and Sleep Apnea. Staff did not discuss the listed diagnosis. (Individual #7)
<table>
<thead>
<tr>
<th>Tag # 1A25</th>
<th>Criminal Caregiver History Screening</th>
<th>Condition of Participation Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NMAC 7.1.9.8</strong> CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:</td>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 36 of 99 Agency Personnel.</td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td><strong>F. Timely Submission:</strong> Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</td>
<td>The following Agency Personnel Files contained Caregiver Criminal History Screenings, which were not specific to the Agency:</td>
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<tr>
<td><strong>NMAC 7.1.9.9</strong> CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:</td>
<td></td>
<td><strong>Provider:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>A. Prohibition on Employment:</strong> A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</td>
<td>(Note: Starting 8/2012 Bright Horizons, Inc. and another DDW agency merged. At the time of the merger, Bright Horizons, Inc. hired/transitional many employees into their organization from the agency merging with them. At the time of the merger, Bright Horizons, Inc. did not complete a new CCHS for all employees who transitioned from previous provider as required by regulation. (NMAC 7.1.9.8)</td>
<td></td>
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</tr>
<tr>
<td><strong>NMAC 7.1.9.11</strong> DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:</td>
<td><strong>Direct Support Personnel (DSP):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. homicide;</td>
<td>• #41 – Date of hire 10/22/2012.</td>
<td></td>
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<td>B. trafficking, or trafficking in controlled substances;</td>
<td>• #43 – Date of hire 10/22/2012.</td>
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<tr>
<td>C. kidnapping, false imprisonment, aggravated assault or aggravated battery;</td>
<td>• #46 – Date of hire 10/22/2012.</td>
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<tr>
<td>D. rape, criminal sexual penetration, criminal</td>
<td>• #52 – Date of hire 10/22/2012.</td>
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<td></td>
<td>• #54 – Date of hire 10/22/2012.</td>
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</tbody>
</table>
| sexual contact, incest, indecent exposure, or other related felony sexual offenses; | • #55 – Date of hire 8/23/2012.  
| E. crimes involving adult abuse, neglect or financial exploitation; | • #60 – Date of hire 10/18/2012.  
| F. crimes involving child abuse or neglect; | • #62 – Date of hire 10/22/2012.  
| G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or | • #65 – Date of hire 10/22/2012.  
| H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection. | • #67 – Date of hire 10/25/2012.  
|   | • #66 – Date of hire 10/22/2012.  
|   | • #68 – Date of hire 10/25/2012.  
|   | • #69 – Date of hire 10/25/2012.  
|   | • #70 – Date of hire 10/26/2012.  
|   | • #72 – Date of hire 10/22/2012.  
|   | • #73 – Date of hire 10/22/2012.  
|   | • #75 – Date of hire 10/26/2012.  
|   | • #76 – Date of hire 10/26/2012.  
|   | • #79 – Date of hire 10/26/2012.  
|   | • #88 – Date of hire 10/22/2012.  
|   | • #90 – Date of hire 10/26/2012.  
|   | • #93 – Date of hire 8/28/2012.  
|   | • #94 – Date of hire 8/28/2012.  
|   | • #96 – Date of hire 10/22/2012.  
|   | • #98 – Date of hire 10/22/2012.  
|   | • #99 – Date of hire 10/22/2012.
- #101 – Date of hire 10/22/2012.
- #102 – Date of hire 10/22/2012.
- #103 – Date of hire 8/27/2012.
- #104 – Date of hire 8/27/2012.
- #106 – Date of hire 10/22/2012.
- #108 – Date of hire 8/27/2012.
- #114 – Date of hire 10/22/12.
- #115 – Date of hire 8/24/2012.

**Service Coordination Personnel (SC):**

- #129 – Date of hire 10/22/2012.
- #130 – Date of hire 8/28/2012.
- #131 – Date of hire 10/22/2012.
Tag # 1A26
Consolidated On-line Registry
Employee Abuse Registry

<table>
<thead>
<tr>
<th>Condition of Participation Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</td>
</tr>
<tr>
<td>Based on record review, the Agency did not maintain documentation in the employee’s personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 41 of 99 Agency Personnel.</td>
</tr>
<tr>
<td>The following Agency Personnel records contained evidence that indicated theEmployee Abuse Registry check was completed after hire:</td>
</tr>
<tr>
<td><strong>Direct Support Personnel (DSP):</strong></td>
</tr>
<tr>
<td>• #58 – Date of hire 5/01/2012, completed 9/12/2012.</td>
</tr>
<tr>
<td>• #84 – Date of hire 2/28/2012, completed 3/21/2012.</td>
</tr>
<tr>
<td><strong>Substitute Care/Respite Personnel:</strong></td>
</tr>
<tr>
<td>• #136 – Date of hire 9/22/2011, completed 10/03/2011.</td>
</tr>
<tr>
<td>The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:</td>
</tr>
</tbody>
</table>
employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

E. **Documentation for other staff.** With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual’s current licensure as a health care professional or current certification as a nurse aide.

F. **Consequences of noncompliance.** The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.


### Chapter 1.IV. General Provider Requirements

#### D. Criminal History Screening:

All personnel shall be screened by the Provider Agency in regard to the employee’s qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records

<table>
<thead>
<tr>
<th>Direct Support Personnel (DSP):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• #41 – Date of hire 10/22/2012</td>
<td></td>
</tr>
<tr>
<td>• #43 – Date of hire 10/22/2012</td>
<td></td>
</tr>
<tr>
<td>• #46 – Date of hire 10/22/2012</td>
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<tr>
<td>• #52 – Date of hire 10/22/2012</td>
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<td>• #54 – Date of hire 10/22/2012</td>
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<tr>
<td>• #55 – Date of hire 8/23/2012</td>
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<tr>
<td>• #60 – Date of hire 10/18/2012</td>
<td></td>
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<tr>
<td>• #62 – Date of hire 10/22/2012</td>
<td></td>
</tr>
<tr>
<td>• #65 – Date of hire 10/22/2012</td>
<td></td>
</tr>
<tr>
<td>• #66 – Date of hire 10/22/2012</td>
<td></td>
</tr>
<tr>
<td>• #67 – Date of hire 10/25/2012</td>
<td></td>
</tr>
<tr>
<td>• #68 – Date of hire 10/25/2012</td>
<td></td>
</tr>
<tr>
<td>• #69 – Date of hire 10/25/2012</td>
<td></td>
</tr>
<tr>
<td>• #70 – Date of hire 10/26/2012</td>
<td></td>
</tr>
<tr>
<td>• #72 – Date of hire 10/22/2012</td>
<td></td>
</tr>
<tr>
<td>• #73 – Date of hire 10/22/2012</td>
<td></td>
</tr>
<tr>
<td>• #75 – Date of hire 10/26/2012</td>
<td></td>
</tr>
<tr>
<td>• #76 – Date of hire 10/26/2012</td>
<td></td>
</tr>
<tr>
<td>• #79 – Date of hire 10/26/2012</td>
<td></td>
</tr>
</tbody>
</table>
Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

- #88 – Date of hire 10/22/2012
- #90 – Date of hire 10/26/2012
- #93 – Date of hire 8/28/2012
- #94 – Date of hire 8/28/2012
- #96 – Date of hire 10/22/2012
- #98 – Date of hire 10/22/2012
- #101 – Date of hire 10/22/2012
- #102 – Date of hire 10/22/2012
- #103 – Date of hire 8/27/2012
- #104 – Date of hire 8/27/2012
- #106 – Date of hire 10/22/2012
- #108 – Date of hire 8/27/2012
- #114 – Date of hire 10/22/2012
- #115 – Date of hire 8/24/2012

Service Coordination Personnel (SC):

- #129 – Date of hire 10/22/2012
- #130 – Date of hire 8/28/2012
- #131 – Date of hire 10/22/2012

(Note: Starting 8/2012 Bright Horizons, Inc. and another DDW agency merged. At the time of the merger, Bright Horizons, Inc.
hired/transitioned many employees into their organization from the agency merging with them. At the time of the merger, Bright Horizons, Inc. did not complete an inquiry into the Employee Abuse Registry as required by regulation (7.1.12 NMAC).
Tag # 1 A28.1  
Incident Mgt. System - Personnel Training

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not ensure Incident Management Training for 8 of 93 Agency Personnel.</td>
<td></td>
</tr>
<tr>
<td>Direct Support Personnel (DSP):</td>
<td></td>
</tr>
<tr>
<td>• Incident Management Training (Abuse, Neglect and Misappropriation of Consumers’ Property) (DSP # 120, 121, 122, 123, 124, 125, 126)</td>
<td></td>
</tr>
<tr>
<td>Service Coordination Personnel (SC):</td>
<td></td>
</tr>
<tr>
<td>• Incident Management Training (Abuse, Neglect and Misappropriation of Consumers’ Property) (SC #131)</td>
<td></td>
</tr>
</tbody>
</table>

**Policy Title:** Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007

**II. POLICY STATEMENTS:**

**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: →

**Provider:**

Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
A. Individuals shall receive services from competent and qualified staff.
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
<table>
<thead>
<tr>
<th>Tag # 1A36 Service Coordination Requirements</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
</table>
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 | Based on record review, the Agency did not ensure that Orientation and Training requirements were met for 1 of 4 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:  
- Person Centered Planning (2-Day) (SC #132)  
- Promoting Effective Teamwork (SC #132) | State your Plan of Correction for the deficiencies cited in this tag here: → |

**CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.

**C. Orientation and Training Requirements:**
Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:

1. Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and

**NMAC 7.26.5.7** "service coordinator": the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the
community service provider agency

**NMAC 7.26.5.11 (b)** service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the service coordinators shall assure the action plans and strategies are implemented consistent with the provisions of the ISP, and shall report to the case manager on ISP implementation and the individual’s progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more “key” community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDTs selection are set forth as follows:

(i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;

(ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;

(iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;

(iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;
<table>
<thead>
<tr>
<th>Tag # 1A37</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Specific Training</td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 4 of 93 Agency Personnel.</td>
</tr>
<tr>
<td><strong>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:</strong> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td>Review of personnel records found no evidence of the following:</td>
<td></td>
</tr>
<tr>
<td><strong>C. Orientation and Training Requirements:</strong> Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</td>
<td><strong>Direct Support Personnel (DSP):</strong></td>
<td></td>
</tr>
<tr>
<td>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</td>
<td>• Individual Specific Training (DSP #64, 81, 92, 94)</td>
<td></td>
</tr>
</tbody>
</table>

**Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:**

A. Individuals shall receive services from competent and qualified staff.
B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.

**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: →

**Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
**Standard of Care**

**Deficiencies**

**Agency Plan of Correction, On-going QA/QI and Responsible Party**

**Date Due**

<table>
<thead>
<tr>
<th>Tag #</th>
<th>CQI System</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A03</td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency has not fully implemented their Continuous Quality Management System as required by standard.</td>
</tr>
</tbody>
</table>

**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.

**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 leading to adverse health

Based on record review, the Agency has not fully implemented their Continuous Quality Management System as required by standard.

- Review of the findings identified during the on-site survey (Sept 16 – 20, 2013) and as reflected in this report of findings, the Agency had multiple deficiencies noted, including Conditions of Participation out of compliance, which indicates the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.

**Provider:**

State your Plan of Correction for the deficiencies cited in this tag here: →

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

Provider:

(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 trends or issues. |
|---|---|---|---|
### Tag # 1A09
**Medication Delivery**
**Routine Medication Administration**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Administration Records (MAR) were reviewed for the months of June, July and September 2013.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Based on record review, 5 of 11 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</td>
<td></td>
</tr>
<tr>
<td>Individual #2</td>
<td></td>
</tr>
<tr>
<td>June 2013</td>
<td></td>
</tr>
<tr>
<td>As indicated by the Medication Administration Records the individual is to take Levothyroxine 100mg (1 time daily).</td>
<td></td>
</tr>
<tr>
<td>According to the Physician’s Orders, Levothyroxine 100mcg is to be taken 1 time daily Medication Administration Record and Physician’s Orders do not match.</td>
<td></td>
</tr>
<tr>
<td>July 2013</td>
<td></td>
</tr>
<tr>
<td>As indicated by the Medication Administration Records the individual is to take Levothyroxine 100mg (1 time daily).</td>
<td></td>
</tr>
<tr>
<td>According to the Physician’s Orders, Levothyroxine 100mcg is to be taken 1 time daily Medication Administration Record and Physician’s Orders do not match.</td>
<td></td>
</tr>
<tr>
<td>Individual #6</td>
<td></td>
</tr>
<tr>
<td>September 2013</td>
<td></td>
</tr>
<tr>
<td>As indicated by the Medication Administration Records and during interview with DSP #121, Individual #6 has been assisted with Cetirizine HCL 10mg daily from 9/1 – 18, yet no Physician’s Orders were found for the following medication:</td>
<td></td>
</tr>
<tr>
<td>• Cetirizine HCL 10mg (1 time daily)</td>
<td></td>
</tr>
</tbody>
</table>

Other Provider Agency requirements and personnel qualifications may be applicable for specific service standards.

**E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.

(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:

(a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;

(b) Prescribed dosage, frequency and method/route of administration, times
and dates of administration;
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;
(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;
(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;

NMAC 16.19.11.8 MINIMUM STANDARDS:
A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:

(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:
   (i) Name of resident;

Individual #7
July 2013
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Cholorhexidine 0.12% (2 times daily) – Blank 7/25 (8 PM); 7/29 (8 AM)

Individual #8
June 2013
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Resource Beneprotein Powder (3 times daily) – Blank 6/29 (PM)

Medication Administration Record did not contain the time the medication should be given. MAR indicated time as "AM, Noon and PM":
- Resource Beneprotein Powder (3 times daily)

July 2013
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Ensure 4oz (2 times daily) – Blank 7/31 (2 PM)
- Gabapentin 300mg (2 times daily) – Blank 7/31 (12 PM)
- Prilosec 20mg (2 times daily) – Blank 7/30 (8 PM)
- Buspirone HCL 30mg (2 times daily) – Blank 7/31 (12 PM)
(ii) Date given;
(iii) Drug product name;
(iv) Dosage and form;
(v) Strength of drug;
(vi) Route of administration;
(vii) How often medication is to be taken;
(viii) Time taken and staff initials;
(ix) Dates when the medication is discontinued or changed;
(x) The name and initials of all staff administering medications.

**Model Custodial Procedure Manual**

**D. Administration of Drugs**

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner’s order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

<table>
<thead>
<tr>
<th><strong>Medication</strong></th>
<th><strong>Dosage</strong></th>
<th><strong>Time</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam 2mg</td>
<td>3 times daily</td>
<td>Blank 7/31 (12 PM)</td>
</tr>
<tr>
<td>Resource Beneprotein Powder</td>
<td>3 times daily</td>
<td>Blank 7/16 (Noon); 7/31 (Noon, PM)</td>
</tr>
</tbody>
</table>

Medication Administration Record did not contain the time the medication should be given. MAR indicated time as “AM, Noon and PM”:

- Resource Beneprotein Powder (3 times daily)

**Individual #13**

**June 2013**

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

- Advair 250/50 Diskus (2 times daily) – Blank 6/14 (8 PM); 6/16 (8 PM)

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Amlodipine 10mg (1 time daily)

- Fluphenazine 5mg (2 times daily)

**July 2013**

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Amlodipine 10mg (1 time daily)

- Fluphenazine 5mg (2 times daily)

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

- Ipratropium Brom. 0.03% (3 times daily) –
September 2013
Medication Administration Records did not contain the diagnosis for which the medication is prescribed:
- Amlodipine 10mg (1 time daily)
- Fluphenazine 5mg (2 times daily)
<table>
<thead>
<tr>
<th>Tag # 1A09.1 Medication Delivery PRN Medication Administration</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
</table>
| 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. E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times | Medication Administration Records (MAR) were reviewed for the months of June, July and September, 2013. Based on record review, 4 of 11 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #2 June 2013 Medication Administration Records did not contain the circumstance for which the medication is to be used: •Cheratussin AC Syrup (PRN) July 2013 Medication Administration Records did not contain the circumstance for which the medication is to be used: •Tylenol 500mg (PRN) Individual #4 July 2013 No evidence of documented Signs/Symptoms were found for the following PRN medication: •Antacid w/Simethicone 200-200-20 Susp – PRN – 7/21 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: •Antacid w/Simethicone 200-200-20 Susp – PRN – 7/21 (given 1 time) Individual #8 July 2013 | }
and dates of administration;
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;

(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;

(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;

NMAC 16.19.11.8 MINIMUM STANDARDS:
A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:
(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications.

Medication Administration Records did not contain the circumstance for which the medication is to be used:
- Oxycodone/Acetaminophen 5-325mg (PRN)

No evidence of documented Signs/Symptoms were found for the following PRN medication:
- Oxycodone/Acetaminophen 5-325mg – PRN – 7/6 (given 1 time)

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
- Oxycodone/Acetaminophen 5-325mg – PRN – 7/6, 7/15 & 7/16 (given 1 time)

Individual #9
July 2013
No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
- Acetaminophen 500mg – PRN – 7/10 (given 1 time)
This documentation shall include:
(i) Name of resident;
(ii) Date given;
(iii) Drug product name;
(iv) Dosage and form;
(v) Strength of drug;
(vi) Route of administration;
(vii) How often medication is to be taken;
(viii) Time taken and staff initials;
(ix) Dates when the medication is discontinued or changed;
(x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual
D. Administration of Drugs
Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner’s order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

Department of Health
Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006
F. PRN Medication
3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to
describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.

4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).

H. Agency Nurse Monitoring
1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual’s response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse’s assessment of the individual and consideration of the individual’s diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual’s condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the
individual’s response to medication.

**Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery**

**Procedure Eff Date: November 1, 2006**

C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).

a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.

4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).
### Tag # 1A27
Incident Mgt. Late and Failure to Report

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on the Incident Management Bureau’s Late and Failure Reports, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 4 of 16 individuals.</td>
<td></td>
</tr>
<tr>
<td>Individual #14</td>
<td>Incident date 9/24/2012. Allegation was Neglect. Incident report was received 9/24/2012. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was “Unconfirmed.”</td>
</tr>
<tr>
<td>Individual #15</td>
<td>Incident date 10/12/2012. Allegation was Abuse/Neglect. Incident report was received 10/17/2012. Failure to Report. IMB Late and Failure Report indicated incident of Abuse/Neglect was “Unconfirmed.”</td>
</tr>
<tr>
<td>Individual #16</td>
<td>Incident date 12/22/2012. Allegation was Law Enforcement Involvement. Incident report was received 12/28/2012. IMB issued a Late Reporting for Law Enforcement Involvement.</td>
</tr>
<tr>
<td>Individual #17</td>
<td>Incident date 1/04/2013. Allegation was Neglect. Incident report was received 1/17/2013. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.”</td>
</tr>
</tbody>
</table>

Provider: State your Plan of Correction for the deficiencies cited in this tag here: →

Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.
<table>
<thead>
<tr>
<th>Tag # 1A31</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Rights/Human Rights</td>
<td>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider’s behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</td>
<td>Statement of Plan of Correction for the deficiencies cited in this tag here:</td>
</tr>
<tr>
<td>Long Term Services Division</td>
<td>Based on record review, the Agency did not ensure the rights of Individuals were not restricted or limited for 1 of 12 Individuals. A review of Agency Individual files found Human Rights Committee notes dated and approved on 1/29/2013 contained restrictions of cell phone use, locked refrigerator/pantry; In addition, observations made by surveyors during the home visit on 9/17/2013 made note of door alarms at the Individual's residence. No documentation was found to evidence restrictions were current of being reviewed at least quarterly by the Human Rights Committee. (#13)</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>Policy Title: Human Rights Committee</td>
<td></td>
<td>}</td>
</tr>
</tbody>
</table>
IV. POLICY STATEMENT  - Human Rights
Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:
• Aversive Intervention Prohibitions
• Psychotropic Medications Use
• Behavioral Support Service Provision.

A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS
Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval.

2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each
individual’s Individual Service Plan.

**Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery**

**Procedure Eff Date: November 1, 2006**

**B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency’s Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).
<table>
<thead>
<tr>
<th>Tag # 6L06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Living Requirements</td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
</tr>
</tbody>
</table>

**CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES**

**A. Support to Individuals in Family Living:** The Family Living Services Provider Agency shall provide and document:

(5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include:

(a) Review, advise, and prompt the implementation of the individual’s ISP Action Plans, schedule of activities and appointments; and

(b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members.

**B. Home Studies.** The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD.

Based on record review, the Agency did not complete all DDSD requirements for approval of each direct support provider for 2 of 3 individuals.

Review of the Agency files revealed the following items were not found, incomplete, and/or not current:

- DDSD Approval for Subcontractor
  - Individual #2 - Not Current
  - Individual #5 - Not Current

Provider:
State your Plan of Correction for the deficiencies cited in this tag here: →

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

}````
Developmental Disabilities (DD) Waiver
Service Standards effective 4/1/2007
CHAPTER 1. I. PROVIDER AGENCY
ENROLLMENT PROCESS
D. Scope of DDSD Agreement

(4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite;

NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER

ELIGIBLE PROVIDERS:
I. Qualifications for community living service providers: There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards.
(1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.
Tag # 6L13
Community Living Healthcare Reqs.

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 3 of 11 individuals receiving Community Living Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td>• Dental Exam</td>
</tr>
<tr>
<td>° Individual #13 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</td>
</tr>
<tr>
<td>• Vision Exam</td>
</tr>
<tr>
<td>° Individual #6 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.</td>
</tr>
<tr>
<td>° Individual #8 - As indicated by collateral documentation reviewed, the exam was completed on 9/2009. As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of current exam was found.</td>
</tr>
<tr>
<td>• Auditory Exam</td>
</tr>
<tr>
<td>° Individual #8 - As indicated by collateral documentation reviewed, exam was completed on 8/24/2009. Follow-up was to be completed in 4 years. No evidence of follow-up found.</td>
</tr>
</tbody>
</table>

Provider:
State your Plan of Correction for the deficiencies cited in this tag here: →

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.

b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.

(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.

(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.

(5) That the physical property and grounds are free of hazards to the individual's health and safety.

(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:

(a) The individual has a primary licensed physician;

(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;

(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;

(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and

(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
<table>
<thead>
<tr>
<th>Tag # 6L25 Residential Health and Safety (SL/FL)</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on observation, the Agency did not ensure that each individual’s residence met all requirements within the standard for 8 of 8 Supported Living and Family Living residences.</td>
</tr>
</tbody>
</table>

**CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS**

**L. Residence Requirements for Family Living Services and Supported Living Services**

(1) Supported Living Services and Family Living Services providers shall assure that each individual’s residence has:

(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;

(b) General-purpose first aid kit;

(c) When applicable due to an individual’s health status, a blood borne pathogens kit;

(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;

(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;

(f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;

(g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP; and

(h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy.

Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:

**Supported Living Requirements:**

- Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#8)

- Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 3, 4, 7, 9, 10, 13)

**Family Living Requirements:**

- Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#2, 5, 6)

*Note: The following Individuals share a residence:*

**Provider:**

State your Plan of Correction for the deficiencies cited in this tag here: →

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.

- #3 and 10
- #4 and 7
- #5 and 6
### Standard of Care

**Service Domain: Medicaid Billing/Reimbursement** – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

### Deficiencies

<table>
<thead>
<tr>
<th>Tag # 5I36</th>
<th>Community Access Reimbursement</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Community Access Services for 1 of 3 individuals.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Individual #12**

- May 2013
  - The Agency billed 72 units of Community Access (H2021 U1) from 5/1/2013 through 5/31/2013. Documentation did not contain the required elements on 5/20/2013.
  - Documentation received accounted for 52 units. One or more of the following elements was not met: 
    - The signature or authenticated name of staff providing the service.

### Agency Plan of Correction, On-going QA/QI and Responsible Party

| Provider: |
| State your Plan of Correction for the deficiencies cited in this tag here: → |

| Provider: |
| Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |

---

QMB Report of Findings – Bright Horizons, Inc. – Metro Region – September 16 - 20, 2013

Survey Report #: Q.14.1.DDW.D2079.5.001.RTN.01.316

Page 62 of 68
treatment plan and/or patient records for the recipient are subject to recoupment.


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.
<table>
<thead>
<tr>
<th>Tag # 5I44</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Habilitation Reimbursement</strong></td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 6 of 7 individuals.</td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here:</td>
</tr>
<tr>
<td><strong>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</strong></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</td>
</tr>
<tr>
<td><strong>A. General:</strong> 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.</td>
<td></td>
</tr>
<tr>
<td><strong>B. Billable Units:</strong> 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:</td>
<td></td>
</tr>
<tr>
<td>(1) Date, start and end time of each service encounter or other billable service interval;</td>
<td></td>
</tr>
<tr>
<td>(2) A description of what occurred during the encounter or service interval; and</td>
<td></td>
</tr>
<tr>
<td>(3) The signature or authenticated name of staff providing the service.</td>
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</tr>
<tr>
<td><strong>MAD-MR: 03-59 Eff 1/1/2004</strong></td>
<td></td>
</tr>
<tr>
<td><strong>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</strong></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>Individual #1</td>
<td></td>
</tr>
<tr>
<td>May 2013</td>
<td></td>
</tr>
<tr>
<td>- The Agency billed 216 units of Adult Habilitation (T2021 U1) from 5/1/2013 through 5/31/2013. Documentation received accounted for 168 units.</td>
<td></td>
</tr>
<tr>
<td>July 2013</td>
<td></td>
</tr>
<tr>
<td>- The Agency billed 192 units of Adult Habilitation (T2021 U1) from 7/1/2013 through 7/31/2013. Documentation received accounted for 185 units.</td>
<td></td>
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<tr>
<td>Individual #3</td>
<td></td>
</tr>
<tr>
<td>May 2013</td>
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</tr>
<tr>
<td>- The Agency billed 128 units of Adult Habilitation (T2021 U2) from 5/1/2013 through 5/31/2013. Documentation received accounted for 72 units.</td>
<td></td>
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<tr>
<td>Individual #4</td>
<td></td>
</tr>
<tr>
<td>May 2013</td>
<td></td>
</tr>
<tr>
<td>- The Agency billed 528 units of Adult Habilitation (T2021 U1) from 5/1/2013 through 5/31/2013. Documentation received accounted for 480 units.</td>
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</tr>
<tr>
<td>Individual #7</td>
<td></td>
</tr>
<tr>
<td>May 2013</td>
<td></td>
</tr>
<tr>
<td>- The Agency billed 336 units of Adult Habilitation (T2021 U1) from 5/1/2013 through 5/31/2013. Documentation received accounted for 312 units.</td>
<td></td>
</tr>
</tbody>
</table>

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.

Individual #8
May 2013
- The Agency billed 528 units of Adult Habilitation (T2021 U1) from 5/1/2013 through 5/31/2013. Documentation received accounted for 524 units.

Individual #13
May 2013
- The Agency billed 480 units of Adult Habilitation (T2021 U2) from 5/1/2013 through 5/31/2013. Documentation received accounted for 264 units.
<table>
<thead>
<tr>
<th>Tag # 6L26</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported Living Reimbursement</td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 4 of 8 individuals.</td>
</tr>
</tbody>
</table>

**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

**Individual #3**
June 2013
- The Agency billed 26 units of Supported Living (T2033 U2) from 6/1/2013 through 6/26/2013. Documentation received accounted for 22 units.

**Individual #4**
May 2013
- The Agency billed 26 units of Supported Living (T2033 UJ U2) from 5/1/2013 through 5/26/2013. Documentation received accounted for 23 units.

**Individual #7**
May 2013
- The Agency billed 26 units of Supported Living (T2033 UJ U1) from 5/1/2013 through 5/26/2013. Documentation received accounted for 25 units.

**Individual #9**
July 2013
- The Agency billed 26 units of Supported Living (T2033 U3) from 7/1/2013 through 7/26/2013. Documentation received accounted for 19 units.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</td>
<td>A. Reimbursement for Supported Living Services</td>
<td></td>
</tr>
<tr>
<td>(1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Billable Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Direct care provided to an individual in the residence any portion of the day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community.</td>
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<td></td>
</tr>
<tr>
<td>(c) Any activities in which direct support staff provides in accordance with the Scope of Services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Non-Billable Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) The Supported Living Services provider shall not bill DD Waiver for Room and Board.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Date: February 6, 2014

To: Ignacio Perez, Executive Director
Provider: Bright Horizons, Inc.
Address: 3809 Academy Parkway S NE
State/Zip: Albuquerque, New Mexico 87109
E-mail Address: iperez@brighthorizonsnm.com

CC: Kimberly J. Allen, President/Chairman of Board
Address: 1267 Camino Del La Tierra
State/Zip: Corrales, New Mexico 87048

Dear Mr. Perez:

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

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

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
Deputy Bureau Chief
Quality Management Bureau/DHI

Q.14.3.DDW.D2079.5.001.RTN.09.037