Date:	December 16, 2011
To:	Lori Anderson, Executive Director
Provider:	Community Options, Inc.
Address:	2720 San Pedro NE Albuquerque
State/Zip:	New Mexico, 87110
E-mail Address:	Lori.Anderson@comop.org
CC:	Robert Stack, CEO/Chairperson
Address:	16 Faber Rd, Princeton
State/Zip:	New Jersey, 08540
Region:	Metro
Survey Date:	October 24 - 28, 2011
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Survey Type:	Routine
Team Leader:	Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Cynthia Nielsen, MSN, RN, ONC, CCM, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Lori Anderson:

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 505-222-8647 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

Tony Fragua, BFA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	October 24, 2011
Present:	**Community Options, Inc.** Joshua Williamson, Service Coordinator Heather Gooch, Quality Assurance Manager/Incident Management Coordinator **DOH/DHI/QMB** Tony Fragua, BFA, Team Lead/Healthcare Surveyor Cynthia Nielsen, MSN,RN, ONC, CCM, Healthcare Surveyor Jennifer Bruns, BSW, Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor
Exit Conference Date:	October 26, 2011
Present:	**Community Options, Inc.** Lori Anderson, Executive Director Heather Gooch, Quality Assurance Manager/Incident Management Coordinator **DOH/DHI/QMB** Tony Fragua, BFA, Team Lead/Healthcare Surveyor Jennifer Bruns, BSW, Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 9 0 - *Jackson* Class Members 9 - Non-*Jackson* Class Members 6 - Adult Habilitation 1 - Community Access 4 - Supported Employment
Persons Served Interviewed	Number: 3
Persons Served Observed	Number: 6 (1 individual did not want to be interviewed and 5 other individuals were not available during the on-site visit)
Person Served Records Reviewed	Number: 9
Direct Support Personnel Interviewed	Number: 5
Direct Support Personnel Record Review	Number: 8
Service Coordinator Record Review	Number: 2

Administrative Files Reviewed

- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry

- Evacuation Drills
- Quality Assurance / Improvement Plan

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

Attachment 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 non compliance.

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

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-222-8647 or email at George.Perrault@state.nm.us. Requests for technical assistance must be requested through your DDSD Regional 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 required six CMS core elements to address ***each deficiency*** of the POC:

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 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 POC:

- 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, Incident Reporting, and Individual-Specific service requirements, etc;
- How accuracy in Billing documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how ISPs 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; 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 POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
    a. Electronically at George.Perrault@state.nm.us *(preferred method)*
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Avenue SW, 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 POC Coordinator.
6. QMB will notify you when your POC has been “approve” 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.
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. For billing deficiencies, you must submit:
   a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
   b. Copies of "void and adjust" forms submitted to correct all over-billed or unjustified units billed identified 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 Plan of Correction Coordinator 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.

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) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. 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.

- "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 one (1) to three (3) 'Conditions of Participation.' 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).

  Providers receiving a repeat determination of 'Partial-Compliance' for repeat deficiencies of CoPs may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- "Non-Compliant 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 and/or has:
  - Four (4) Conditions of Participation out of compliance.
  - Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
  - Any finding of actual harm or Immediate Jeopardy.

  The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

  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.

Attachment C

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

Introduction:

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

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: http://dhi.health.state.nm.us/qmb
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRC process, email the IRF Chairperson, Scott Good at scott.good@state.nm.us for assistance.

The following limitations apply to the IRF process:

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

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

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

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

Agency: **Community Options, Inc. - Metro Region**
Program: Developmental Disabilities Waiver
Service: Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Routine Survey
Date of Survey: **October 24 - 28, 2011**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08 Agency Case File	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including 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	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 3 of 9 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current: • Speech Therapy Plan (#5) • **Dental Exam** ° Individual #5 - As indicated by collateral documentation reviewed, exam was completed on 10/21/2010. Follow-up was to be completed in 6 months. No evidence of follow-up found. • **Vision Exam** ° Individual #5 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #9 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. • **Auditory Exam** ° Individual #2 - As indicated by collateral	Provider: In addition to stating the Plan of Correction for these findings, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. ______________________________	

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.	documentation reviewed, exam was completed on 9/24/2009. Follow-up was to be completed in 2 years. No evidence of follow-up found.		

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.			

Tag # 1A32 & 6L14 ISP Implementation	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and 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]	Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 2 of 9 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #9 • "… will volunteer in areas of community need." Action Step: "… and staff will research available community volunteerism opportunities," is to be completed 2 times per month. Outcome was not being completed at the required frequency for 7/2011 - 9/2011. • Action Steps: "… will choose a volunteer activity to engage in, and complete necessary steps to do this," is to be completed Once or as needed. Outcome was not being completed at the required frequency for 7/2011 - 8/2011. • Action Steps: "… will volunteer," is to be completed 1 times per month. Outcome was not being completed at the required frequency for 7/2011 - 9/2011. **Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #6 • None found for 7/2011 - 9/2011	Provider: In addition to stating the Plan of Correction for these findings, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. ______________________________	

	• No Outcomes or DDSD exemption/decision justification found for Community Access Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver."		

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **E. Provider Agency Reporting Requirements:** All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD.	Based on record review, the Agency failed to complete quarterly reports as required for 1 of 9 individuals receiving Community Inclusion services. **Adult Habilitation Quarterly Reports** • Individual #9 - None found for 1/2011 - 3/2011	Provider: In addition to stating the Plan of Correction for these findings, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

Tag # 5I22 SE Agency Case File	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS** **D. Provider Agency Requirements** (1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits. (2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items: (a) Quarterly progress reports; (b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD; (c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will	Based on record review, the Agency failed to maintain a confidential case file for each individual for 1 of 4 individuals receiving Supported Employment Services. The following were not found, incomplete and/or not current: • Vocational Assessment (#5)	Provider: In addition to stating the Plan of Correction for these findings, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

complete specific tasks including the individual, as well and a review and reporting mechanism for mutual accountability; and (d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973. New Mexico Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy **Policy Title: Vocational Assessment Profile Policy Eff July 16, 2008** **I. PURPOSE** The intent of the policy is to ensure that individuals are identified who could benefit from Vocational Assessment Profiles (VAPs) and are supported to access this support. **II. POLICY STATEMENT** Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A20 Direct Support Personnel Training	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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 (2) Individual-specific training for each individual under his or her direct care, as	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 3 of 8 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Foundation for Health & Wellness (DSP #47) • First Aid (DSP #46) • CPR (DSP #46) • Rights & Advocacy (DSP #41) • Teaching & Support Strategies (DSP #41)	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. ________________________________	

described in the individual service plan, prior to working alone with the individual. **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. 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 services.			

Tag # 1A22 Agency Personnel Competency	CoP Level Deficiency negative outcome or potential for a negative outcome		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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. **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;	After an analysis of the evidence it has been determined the there is a significant potential for a negative outcome to occur Based on interview, the Agency failed to ensure that training competencies were met for 3 of 5 Direct Service Professionals. **When DSP were asked if they received training on the Individual's Speech Therapy Plan and what the plan covered, the following was reported:** • DSP #46 stated, "I will be trained next week." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #2) • DSP #46 stated, "Not Yet." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #8) **When DSP were asked if they received training on the Individual's Occupational Therapy Plan and what the plan covered, the following was reported:** • DSP #46 stated, "That I don't know, I don't think he does." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #8) **When DSP were asked if they received training on the Individual's Health Care Plans and what the plan covered, the following was reported:** • DSP #47 stated, "Just Aspiration." As	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. ________________________________	

(4) Direct service personnel shall meet the 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 (5) 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.**	indicated by the Agency file/eCHAT, the Individual has Health Care Plans for Falls & Respiratory. (Individual #3) • DSP #43 stated, "Yes." DSP was asked to describe the Health Care Plans, DSP #43 wasn't able to locate information from Agency Case File and describe to surveyor. As indicated by the Agency file, the Individual has Health Care Plans for Oral Care, Seizures & Gastrointestinal. (Individual #4) **When DSP were asked if they received training on the Individual's Crisis Plans/Medical Emergency Response Plans and what the plan covered, the following was reported:** • DSP #47 stated, "Just about Aspiration." As indicated by the Agency file/eCHAT, the Individual has Crisis Plans/Medical Emergency Response Plans for Falls & Respiratory. (Individual #3) **When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was reported:** • DSP #43 stated, "No." As indicated by the Individual Specific Training Section of the ISP, the Individual has MERPs for: Corn, Nuts and Soy Allergies and Lactose Intolerance. (Individual #4)		

March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff.			

Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. **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. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.	Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 1 of 10 Agency Personnel. **Direct Support Personnel (DSP):** • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#44)	Provider: In addition to stating the Plan of Correction for these findings, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. ___	

Tag # 1A36 Service Coordination Requirements	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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:** Orie (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 commu 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	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 2 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: • Pre-Service Manual (SC #49)	Provider: In addition to stating the Plan of Correction for these findings, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

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;			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A03 CQI System	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation;	Based on record review, the Agency failed to develop and implement a Continuous Quality Management System. Review of the Agency's Continuous Quality Improvement Plan provided during the on-site survey did not contain the components required by Standards. The Agency's CQI Plan did not contain the following components: (4) Trends in medication and medical incidents leading to adverse health events;	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. ______________________________	

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 # 1A15.1 Nurse Availability	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **NEW MEXICO NURSING PRACTICE ACT CHAPTER 61, ARTICLE 3** I. "licensed practical nursing" means the practice of a directed scope of nursing requiring basic knowledge of the biological, physical, social and behavioral sciences and nursing procedures, which practice is at the direction of a registered nurse, physician or dentist licensed to practice in this state. This practice includes but is not limited to: (1) contributing to the assessment of the health status of individuals, families and communities; (2) participating in the development and modification of the plan of care; (3) implementing appropriate aspects of the plan of care commensurate with education and verified competence; (4) collaborating with other health care professionals in the management of health care; and (5) participating in the evaluation of responses to interventions;	Based on interview, the Agency failed to ensure nursing services were available as needed for 3 of 9 individuals. When Direct Service Professionals (DSP) were asked about the availability of their agency nurse, the following was reported: • DSP #47 stated, “I’m not sure, I’ll have to check. (I’m) not one on site at all times.” • DSP #41 stated, “No, at home only.”	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. ________________________________	

Tag # 1A15.2 & 5I09 - Healthcare Documentation	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities** (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so.	Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 4 of 9 individuals. The following were not found, incomplete and/or not current: • Health Assessment Tool/eCHAT (#1) • Aspiration Risk Screening Tool (#5) • **Special Health Care Needs:** • Nutritional Plan ° Individual #9 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • **Health Care Plans** • Respiratory ° Individual #3 - According to eCHAT the individual is required to have a plan. No evidence of plans found. • Skin and Wound ° Individual #5 - According to eCHAT the individual is required to have a plan. No evidence of plans found. • BMI (Body Mass Index) ° Individual #9 - According to eCHAT the individual is required to have a plan. No evidence of plans found. • Oral Care ° Individual #9 - According to eCHAT the individual is required to have a plan. No evidence of plans found. • **Crisis Plans/Medical Emergency Response Plans**	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. ———————————————	

However, the agency nurse must be available to assist the caregiver upon request. (c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. (d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **(2) Health related plans** (a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately	• Respiratory ° Individual #3 - According to eCHAT the individual is required to have a plan. No evidence of plans found. • Allergies ° Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plans found.		

designated healthcare professional. (b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. (c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. (d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings. (3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended): (a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition. (b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal. (c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff,			

family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan. (d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions. (e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings. (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization. (g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author. (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed. **(4) General Nursing Documentation** (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person. (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and			

progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **B. IDT Coordination** (1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and (2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan. **Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010** F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).			

4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911. 5. Emergency contacts with phone numbers. 6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.			

Tag # 1A27 Incident Mgt Late & Failure to Report	Standard Level Deficiency		
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **A. Duty To Report:** **(1)** All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. **(2)** All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include: **(a)** an environmental hazardous condition, which creates an immediate threat to life or health; or **(b)** admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider. **(3)** All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. **B. Notification**: **(1) Incident Reporting:** Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and 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.	Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 13 of 20 individuals. Individual #1 • Incident date 12/16/2010. Allegation was Exploitation & Law Enforcement Involvement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed." Individual #9 • Incident date 12/16/2010. Allegation was Exploitation & Law Enforcement Involvement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed." Individual #10 • Incident date 12/16/2010. Allegation was Exploitation & Law Enforcement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed." Individual #11 • Incident date 12/16/2010. Allegation was Exploitation & Law Enforcement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed." Individual #12 • Incident date 12/16/2010. Allegation was	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

	Exploitation & Law Enforcement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed." Individual #13 • Incident date 12/16/2010. Allegation was Exploitation & Law Enforcement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed." Individual #14 • Incident date 12/16/2010. Allegation was Exploitation & Law Enforcement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed." Individual #15 • Incident date 12/16/2010. Allegation was Exploitation & Law Enforcement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed." Individual #16 • Incident date 12/16/2010. Allegation was Exploitation & Law Enforcement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed." Individual #17 • Incident date 12/16/2010. Allegation was Exploitation & Law Enforcement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation		

	was "Confirmed." Individual #18 • Incident date 12/16/2010. Allegation was Exploitation & Law Enforcement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed." Individual #19 • Incident date 12/16/2010. Allegation was Exploitation & Law Enforcement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed." Individual #20 • Incident date 12/16/2010. Allegation was Exploitation & Law Enforcement. Incident report was received 12/22/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed."		

Tag # 1A31 Client Rights/Human Rights	Standard Level Deficiency		
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] **Long Term Services Division** **Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003** **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service provider agencies. The purpose of these	Based on record review, the Agency failed to ensure the rights of Individuals was not restricted or limited for 1 of 2 Individuals. A review of Agency Individual files found no documentation of Positive Behavior Plans and/or Positive Behavior Crisis Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (#4) A review of Agency Individual files indicated 1 of 2 Individuals required Human Rights Committee Approval for restrictions. No documentation was found regarding current Human Rights Approval for the following: • Physical Restraint (MANDT & removal of sharps) - (Individual #4)	Provider: In addition to stating the Plan of Correction for these findings, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. ______________________________	

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).			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Financial Accountability – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver*.			
Tag # 5I25 Supported Employment Reimbursement	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND**	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 2 of 4 individuals Individual #2 July 2011 • The Agency billed 2 units of Supported Employment (T2013/U2) on 7/7/2011. Documentation did not contain a signature/authenticated name of the staff providing the service to justify 2 units billed. • The Agency billed 2 units of Supported Employment (T2013/U2) on 7/8/2011. Documentation did not contain a signature/authenticated name of the staff providing the service to justify 2 units billed. • The Agency billed 2 units of Supported Employment (T2013/U2) on 7/18/2011. Documentation did not contain a signature/authenticated name of the staff providing the service to justify 2 units billed. • The Agency billed 2 units of Supported Employment (T2013/U2) on 7/21/2011. Documentation did not contain an end time on 7/21/2011 to justify 2 units billed. • The Agency billed 2 units of Supported Employment (T2013/U2) on 7/28/2011. Documentation did not contain an end time on 7/28/2011 to justify 2 units billed. Individual #6	Provider: In addition to stating the Plan of Correction for these findings, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. ______________________________	

DOCUMENTATION REQUIREMENTS: Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS** **E. Reimbursement** (1) Billable Unit: (a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job. (b) The **billable unit for Individual Supported Employment** is one hour with a maximum of four hours a month. The Individual Supported Employment hourly rate is for face-to-face time which is supported by non face-to-face activities as specified in the ISP and the performance based contract as negotiated annually with the provider agency. Individual Supported Employment is a minimum of one unit per month. If an individual needs less then one hour of face-to-face service per month the IDT Members shall consider whether Supported Employment Services need to be continued. Examples of non face-to-face services include: (i) Researching potential employers via telephone, Internet, or visits; (ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents; (iii) Arranging appointments for job tours, interviews, and job trials; (iv) Documenting job search and acquisition progress;	August 2011 • The Agency billed 4 units of Supported Employment (T2013/U2) 9/22 & 9/23. No documentation received to justify billing.		

(v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual's progress, needs and satisfaction; and (vi) Meetings with individual surrounding job development or retention not at the employer's site. (c) Intensive Supported Employment services are intended for individuals who need one-to-one, face-to-face support for 32 or more hours per month. The billable unit is one hour. (d) Group Supported Employment is a fifteen-minute unit. (e) Self-employment is a fifteen minute unit. (4) Billable Activities include: (a) Activities conducted within the scope of services; (b) Job development and related activities for up to ninety (90) calendar days) that result in employment of the individual for at least thirty (30) calendar days; and (c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDSD Regional Office.			

Tag # 5I44 Adult Habilitation Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 5 of 6 individuals. Individual #1 July 2011 • The Agency billed 86 units of Adult Habilitation (T2021/U2) from 7/5/2011 through 7/8/2011. Documentation received accounted for 68 units. • The Agency billed 103 units of Adult Habilitation (T2021/U2) from 7/11/2011 through 7/15/2011. Documentation received accounted for 84 units. • The Agency billed 92 units of Adult Habilitation (T2021/U2) from 7/18/2011 through 7/22/2011. Documentation received accounted for 77 units. • The Agency billed 101 units of Adult Habilitation (T2021/U2) from 7/25/2011 through 7/29/2011. Documentation received accounted for 84 units. August 2011 • The Agency billed 114 units of Adult Habilitation (T2021/U2) from 8/1/2011 through 8/5/2011. Documentation received accounted for 102 units. Individual #3 July 2011 • The Agency billed 23 units of Adult Habilitation (T2021/U2) on 7/1/2011. Documentation did not contain a signature/authenticated name of the staff providing the service to justify 23 units billed.	Provider: In addition to stating the Plan of Correction for these findings, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. ________________________________	

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	August 2011 • The Agency billed 96 units of Adult Habilitation (T2021/U2) from 8/22/2011 through 8/26/2011. Documentation received accounted for 72 units. September 2011 • The Agency billed 118 units of Adult Habilitation (T2021/U2) from 9/12/2011 through 9/16/2011. Documentation received accounted for 94 units. Individual #4 July 2011 • The Agency billed 92 units of Adult Habilitation (T2021/U1) from 7/11/2011 through 7/12/2011. Documentation received accounted for 48 units. September 2011 • The Agency billed 44 units of Adult Habilitation (T2021/U1) on 9/22 & 9/23. No documentation received to justify 44 units billed. Individual #7 July 2011 • The Agency billed 23 units of Adult Habilitation (T2021/U2) on 7/1/2011. No documentation received to justify 23 units billed. August 2011 • The Agency billed 108 units of Adult Habilitation (T2021/U2) from 8/22/2011 through 8/26/2011. Documentation received accounted for 90 units. September 2011 • The Agency billed 117 units of Adult Habilitation (T2021/U2) from 9/19/2011 through 9/23/2011. Documentation received accounted for 94 units.		

	Individual #9 August 2011 • The Agency billed 62 units of Adult Habilitation (T2021/U2) from 8/8/2011 through 8/12/2011. No documentation received to justify 62 units billed.		

Date: March 13, 2012

To: Ms. Lori Anderson, Executive Director

Provider: Community Options, Inc.
Address: 2720 San Pedro NE
State/Zip: Albuquerque, New Mexico 87110

CC: Mr. Robert Stack, CEO
Community Options, Inc.
16 Farber Road
Princeton, New Jersey 08540

Region: Metro
Survey Date: October 24 - 28, 2011
Program Surveyed: Developmental Disabilities Waiver
Services Surveyed: Community Inclusion (Adult Habilitation, Community Access and Supported Employment)
Survey Type: Routine

Dear Ms. Anderson:

The Division of Health Improvement Quality Management Bureau received, reviewed and approved the documents you submitted for your Plan of Correction.

<u>Your Plan of Correction is closed.</u>

To maintain ongoing compliance with regulations and standards, continue to use the QA/QI processes in your Plan of Correction, including:

- The agency conducts Quality Assurance meetings on a monthly basis in which 10% of all program files are audited to ensure compliance. Program files are randomly selected and reviewed. The audit tool used to audit our charts is the tool used by DHI.
- A staff-training database is maintained by the Coordinator and reviewed as a part of the monthly Quality Assurance meeting.
- The Day Program Manager meets with the staff twice per week. During these meetings, continual reviews of training competencies are completed.
- Ongoing, documented training of staff in compliance requirements

Consistent implementation of your QA/QI processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, and for the work you and your team perform.

Sincerely,

George Perrault, MBA
Plan of Correction Coordinator

Cc: DHI
DDSD