Dear Mr. Johnson;

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:

**Compliance with all Conditions of Participation.**

This determination is based on your agency’s compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Standard Level deficiencies identified 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,

Amanda Castañeda, MPA

Amanda Castañeda, MPA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: September 3, 2013

Present:

Community Options, Inc.
Hector Johnson, Assistant Executive Director

DOH/DHI/QMB
Amanda Castañeda, MPA, Team Lead/Healthcare Surveyor
Mari Chavez, BSW, Healthcare Surveyor

Exit Conference Date: September 5, 2013

Present:

Community Options, Inc.
Jose Solis, Quality Assurance
Crystal Reyes, Service Coordinator
Angelita Chavez, Service Coordinator
Hector Johnson, Assistant Executive Director
Ruth Medina, RN

DOH/DHI/QMB
Amanda Castañeda, MPA, Team Lead/Healthcare Surveyor
Mari Chavez, BSW, Healthcare Surveyor
Deb Russell, BS, Healthcare Surveyor

DDSD - SW Regional Office
Scott Doan, Regional Director

Administrative Locations Visited Number: 1

Total Sample Size Number: 10

- Jackson Class Members
- Non-Jackson Class Members
- Supported Living
- Family Living
- Adult Habilitation
- Supported Employment

Total Homes Visited Number: 4

- Supported Living Homes Visited Number: 2
- Family Living Homes Visited Number: 2

Persons Served Records Reviewed Number: 10

Persons Served Interviewed Number: 6

Persons Served Observed Number: 4 (4 Individuals were not available during the on-site visit, as 1 individual was home sick and 3 others were out in the community and not available)

Direct Support Personnel Interviewed Number: 9

Direct Support Personnel Records Reviewed Number: 79
Substitute Care/Respite Personnel
Records Reviewed Number: 3
Service Coordinator Records Reviewed Number: 3

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
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 Deputy Chief/Plan of Correction Coordinator at 505-222-8650 or 505-699-9356 or email at Crystal.Lopez-Beck@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 QMB Deputy Chief/POC Coordinator, Crystal Lopez-Beck at 505-222-8650 or 505-699-9356 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional 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 “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 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.
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.
<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> – 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>
<td></td>
</tr>
<tr>
<td><strong>Tag # 1A08</strong> Agency Case File</td>
<td><strong>Standard Level Deficiency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 10 individuals.</td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical Therapy Plan (#2)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • Dental Exam  
  ◦ Individual #3 - As indicated by collateral documentation reviewed, the exam was completed in 7/2012. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found. | | | |
| • Vision Exam  
  ◦ Individual #3 - As indicated by collateral documentation reviewed, exam was completed in 7/2012. Follow-up was to be completed in 1 year. No evidence of follow-up found. | | | |
| | | | |
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.

Individual #4 - As indicated by collateral documentation reviewed, exam was completed on 3/8/2012. Follow-up was to be completed in 1 year. No evidence of follow-up found.
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 # 1A08.1 Agency Case File - Progress Notes</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 1 of 10 Individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>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.</td>
<td>Review of the Agency individual case files revealed the following items were not found:</td>
<td></td>
</tr>
<tr>
<td>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:</td>
<td>Family Living Progress Notes/Daily Contact Logs</td>
<td></td>
</tr>
<tr>
<td>(3) Progress notes and other service delivery documentation;</td>
<td>- Individual #1 - None found for 6/15, 16, 22, 23 and 7/27 – 28, 2013.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>
### Tag #1 A32 and 6L14
#### Individual Service Plan Implementation

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<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 outcomes and action plan.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
<td></td>
</tr>
<tr>
<td><strong>Administrative Files Reviewed:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</strong></td>
<td></td>
</tr>
<tr>
<td>Individual #6</td>
<td></td>
</tr>
<tr>
<td>• “Select task using communication device” is to be completed 1 time per week. Action Step was not being completed at the required frequency for 7/2013.</td>
<td></td>
</tr>
<tr>
<td><strong>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</strong></td>
<td></td>
</tr>
<tr>
<td>Individual #3</td>
<td></td>
</tr>
<tr>
<td>• “… will work on her ceramic projects,” is to be completed 2 times per week. Action Step was not being completed at the required frequency for 2/2013 - 7/2013.</td>
<td></td>
</tr>
<tr>
<td>• “… will work on her collage,” is to be completed 2 times per week. Action Step was not being completed at the required frequency for 2/2013 and 4/2013 - 7/2013.</td>
<td></td>
</tr>
</tbody>
</table>

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]

- "Work on invitation," is to be completed 1 time per week. Action Step was not being completed at the required frequency for 5/2013.
- "Invite a friend and go to lunch," is to be completed 1 time per month. Action Step was not being completed at the required frequency for 7/2013.

Individual #8
- “Document in her journal,” is to be completed 2 times per week. Action Step was not being completed at the required frequency for 6/2013 - 7/2013.

Individual #9
- “…. will be given two choices of places to go,” is to be completed 2 times per week. Action Step was not being completed at the required frequency for 5/2013 – 7/2013.

- “…. will go to the location she has chosen,” is to be completed 2 times per week. Action Step was not being completed at the required frequency for 5/2013 – 7/2013.

Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #4
- “Find ten items in one store aisle,” is to be completed 2 times per week. Action Step was not being completed at the required frequency for 5/2013 - 6/2013.
### Tag # 6L14
**Residential Case File**


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

**A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual’s home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual’s home, the complete and current confidential case file for each individual shall be maintained at the agency’s administrative site. Each file shall include the following:

1. Complete and current ISP and all supplemental plans specific to the individual;
2. Complete and current Health Assessment Tool;
3. Current emergency contact information, which includes the individual’s address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician’s name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;
4. Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);
5. Data collected to document ISP Action Plan implementation

**Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 5 Individuals receiving Family Living Services/Supported Living Services.**

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

- Speech Therapy Plan (#6)

**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: →

)}
(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 practitioner’s 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
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.
**Service Domain: Qualified Providers** – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.

<table>
<thead>
<tr>
<th>Tag # 1A11.1</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transportation Training</strong></td>
<td>Based on record review and interview, 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 4 of 79 Direct Support Personnel.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
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<td>for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle</td>
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<td>5. Operating wheelchair lifts (if applicable to the staff’s role)</td>
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<td>6. Wheelchair tie-down procedures (if applicable to the staff’s role)</td>
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<td>7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)</td>
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<tr>
<td>Tag #</td>
<td>A20</td>
<td>Direct Support Personnel Training</td>
<td>Standard Level Deficiency</td>
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<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>
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<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: (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 described in the individual service plan, prior to working alone with the individual.</td>
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<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Based on record review, the Agency did not ensure Orientation and Training requirements were met for 1 of 79 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>
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<tr>
<td></td>
<td></td>
<td>• Teaching and Support Strategies (DSP #118)</td>
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<td></td>
<td></td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
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<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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</tbody>
</table>
**Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:**

<table>
<thead>
<tr>
<th>A.</th>
<th>Individuals shall receive services from competent and qualified staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.</td>
<td>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.</td>
</tr>
<tr>
<td>C.</td>
<td>Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</td>
</tr>
<tr>
<td>D.</td>
<td>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.</td>
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<tr>
<td>E.</td>
<td>Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</td>
</tr>
<tr>
<td>F.</td>
<td>Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</td>
</tr>
<tr>
<td>G.</td>
<td>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.</td>
</tr>
<tr>
<td>H.</td>
<td>Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.</td>
</tr>
<tr>
<td>I.</td>
<td>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.</td>
</tr>
<tr>
<td>Tag # 1A22</td>
<td>Agency Personnel Competency</td>
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<tr>
<td></td>
<td>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</td>
</tr>
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</table>
individual;

(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. March 1, 2007 - II. POLICY STATEMENTS:
A. Individuals shall receive services from competent and qualified staff.
<table>
<thead>
<tr>
<th>Tag # 1A25</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Caregiver History Screening</td>
<td>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 1 of 85 Agency Personnel. The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</td>
</tr>
</tbody>
</table>

**Tag # 1A25**  
**Criminal Caregiver History Screening**

**NMAC 7.1.9.8**  
**CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:**

**F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.

**NMAC 7.1.9.9**  
**CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:**

**A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.

**NMAC 7.1.9.11**  
**DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:

- **A. homicide;**
- **B. trafficking, or trafficking in controlled substances;**
- **C. kidnapping, false imprisonment, aggravated assault or aggravated battery;**
- **D. rape, criminal sexual penetration, criminal**
sexual contact, incest, indecent exposure, or other related felony sexual offenses;

E. crimes involving adult abuse, neglect or financial exploitation;

F. crimes involving child abuse or neglect;

G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or

H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.
<table>
<thead>
<tr>
<th>Tag # 1A26</th>
<th>Consolidated On-line Registry Employee Abuse Registry</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:</td>
<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 1 of 85 Agency Personnel.</td>
<td>Provider: Statement of Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:</td>
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<tr>
<td>Direct Support Personnel (DSP):</td>
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</table>

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

**Service Domain: Health and Welfare** – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.

### Tag # 1A09 Medication Delivery

#### Routine Medication Administration

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
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<tbody>
<tr>
<td>Medication Administration Records (MAR) were reviewed for the months of July, August and September 2013.</td>
<td></td>
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<tr>
<td>Based on record review, 3 of 5 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</td>
<td></td>
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<tr>
<td>Individual #6</td>
<td></td>
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<tr>
<td>July 2013</td>
<td></td>
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<tr>
<td>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</td>
<td></td>
</tr>
<tr>
<td>• Prevident Oral Rinse (1 time daily) – Blank 7/1 – 31 8:00 PM</td>
<td></td>
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<tr>
<td>Individual #7</td>
<td></td>
</tr>
<tr>
<td>July 2013</td>
<td></td>
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<tr>
<td>Medication Administration Records did not contain the strength of the medication which is to be given:</td>
<td></td>
</tr>
<tr>
<td>• Potassium Chloride 10% 30ml by mouth (2 times daily)</td>
<td></td>
</tr>
<tr>
<td>August 2013</td>
<td></td>
</tr>
<tr>
<td>Medication Administration Records did not contain the strength of the medication which is to be given:</td>
<td></td>
</tr>
<tr>
<td>• Potassium Chloride 10% 30ml by mouth (2 times daily)</td>
<td></td>
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</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: →

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**QMB Report of Findings – Community Options, Inc. – Southwest Region – September 3-5, 2013**

Survey Report #: Q.14.1.DDW.D3124.3.001.RTN.01.310
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 administering 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:

September 2013
Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:
- Potassium Chloride 10% (2 times daily)

Medication Administration Records did not contain the strength of the medication which is to be given:
- Potassium Chloride 10% (2 times daily)

Individual #8
September 2013
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Multivitamin (1 time daily) – Blank 9/2 (8:00 AM)
- Calcium 600mg (1 time daily) – Blank 9/2 (8:00 AM)
- Vitamin E 400 IU (1 time daily) – Blank 9/2 (8:00 AM)
- Claritin 10mg (1 time daily) – Blank 9/2 (8:00 AM)
- Senna (2 time daily) – Blank 9/2 (8:00 AM and 8:00 PM)
- Aspirin EC 81mg (Every other day – even days) – Blank 9/2 (8:00 AM)
- Omeprazole ER 20mg dosage (1 time daily) – Blank 9/2 (8:00 AM)
- Flonase 50mcg (1 time daily) – Blank 9/2
(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:

- Name of resident;
- Date given;
- Drug product name;
- Dosage and form;
- Strength of drug;
- Route of administration;
- How often medication is to be taken;
- Time taken and staff initials;
- Dates when the medication is discontinued or changed;
- 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.

(8:00 AM)

- Baclofen 10mg (2 times daily) – Blank 9/2
  - (8:00 AM and 8:00 PM)
Tag # 1A15.2 and 5I09
Healthcare Documentation


**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 based on record review.

Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required per standard for 1 of 10 individuals.

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

- **Meal Time Plan**
  - Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.

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: →

}
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. 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,
(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 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.


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.
<table>
<thead>
<tr>
<th>Tag # 6L25</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Health and Safety (SL/FL)</td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</strong></td>
<td><strong>Based on observation, the Agency did not ensure that each individuals’ residence met all requirements within the standard for 4 of 4 Supported Living and Family Living residences.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>L. Residence Requirements for Family Living Services and Supported Living Services</strong></td>
<td><strong>Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:</strong></td>
<td></td>
</tr>
<tr>
<td>(1) Supported Living Services and Family Living Services providers shall assure that each individual’s residence has:</td>
<td><strong>Supported Living Requirements:</strong></td>
<td></td>
</tr>
<tr>
<td>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</td>
<td>• 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 (#5, 7, 8)</td>
<td></td>
</tr>
<tr>
<td>(b) General-purpose first aid kit;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) When applicable due to an individual’s health status, a blood borne pathogens kit;</td>
<td><strong>Family Living Requirements:</strong></td>
<td></td>
</tr>
<tr>
<td>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;</td>
<td>• General-purpose first aid kit (#1)</td>
<td></td>
</tr>
<tr>
<td>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;</td>
<td>• 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, 6)</td>
<td></td>
</tr>
<tr>
<td>(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;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(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. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 6)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The following Individuals share a residence:
- #7, 8
unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.
| Service Domain: Medicaid Billing/Reimbursement | State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. |
| Tag # 5125 | Standard Level Deficiency | Agency Plan of Correction, On-going QA/QI and Responsible Party | Date Due |
| CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION | Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 1 of 1 individual |
| 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. | Individual #4 |
| 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; | July 20013 |
| (2) A description of what occurred during the encounter or service interval; and | • The Agency billed 5 units of Supported Employment (T2013, U3) on 7/5/2013. Documentation did not contain the required elements on 7/5/2013. Documentation received accounted for 0 units. One or more of the following elements was not met: |
| (3) The signature or authenticated name of staff providing the service. | ➢ Date, start and end time of each service encounter or other billable service interval. |
| MAD-MR: 03-59 Eff 1/1/2004 | Provider: |
| 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: | State your Plan of Correction for the deficiencies cited in this tag here: → |
| Providers must maintain all records necessary to fully disclose the extent of the services | Provider: |
| | Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |

QMB Report of Findings – Community Options, Inc. – Southwest Region – September 3 - 5, 2013

Survey Report #: Q.14.1.DDW.D3124.3.001.RTN.01.310

Page 44 of 54
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.


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;
(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

<table>
<thead>
<tr>
<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 Adult Habilitation Services for 3 of 9 individuals.</td>
</tr>
</tbody>
</table>

Individual #1
May 2013
- The Agency billed 112 units of Adult Habilitation (T2021, U2) from 5/6/2013 through 5/10/2013. Documentation received accounted for 108 units.
- The Agency billed 120 units of Adult Habilitation (T2021, U2) from 5/13/2013 through 5/17/2013. Documentation received accounted for 112 units.

Individual #8
July 2013
- The Agency billed 96 units of Adult Habilitation (T2021, U1) from 7/1/2013 through 7/5/2013. Documentation received accounted for 72 units.

Individual #10
July 2013
- The Agency billed 114 units of Adult Habilitation (T2021, U3, U1) from 7/8/2013 through 7/12/2013. Documentation did not contain the required elements on 7/11/2013. Documentation received accounted for 91 units. One or more of the following elements was not met:
  - A description of what occurred during the encounter or service interval;
  - The signature or authenticated name of staff providing the service.

**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:**

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.


CHAPTER 5 XVI. REIMBURSEMENT

A. Billable Unit. A billable unit for Adult Habilitation Services is in 15-minute increments per 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.

- The Agency billed 112 units of Adult Habilitation (T2021, U3, U1) from 7/22/2013 through 7/26/2013. Documentation received accounted for 111 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 1 of 3 individuals.</td>
</tr>
</tbody>
</table>

**Individual #7**  
**May 2013**  
- The Agency billed 7 units of Supported Living (T2033, U1, UJ) from 5/6/2013 through 5/10/2013. Documentation received accounted for 5 units.

**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: →

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**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

CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES

A. Reimbursement for Supported Living Services

(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.

(2) Billable Activities

(a) Direct care provided to an individual in the residence any portion of the day.

(b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community.

(c) Any activities in which direct support staff provides in accordance with the Scope of Services.

(3) Non-Billable Activities

(a) The Supported Living Services provider shall not bill DD Waiver for Room and Board.

(b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services.

(c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.
### Tag # 6L27
**Family Living Reimbursement**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</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 Family Living Services for 2 of 2 individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

#### Individual #1
**June 2013**
- The Agency billed 25 units of Family Living (T2033) from 6/1/2013 through 6/25/2013. Documentation did not contain the required elements on 6/15, 16, 22 and 23. Documentation received accounted for 21 units. One or more of the following elements was not met:
  - No documentation found.

#### Individual #6
**June 2013**
- The Agency billed 28 units of Family Living (T2033) from 6/1/2013 through 6/28/2013. Documentation did not contain the required elements on 6/20/2013. Documentation received accounted for 27 units. One or more of the following elements was not met:
  - The signature or authenticated name of staff providing the service.

#### Individual #2
**June 2013**
- The Agency billed 29 units of Family Living (T2033) from 7/1/2013 through 7/29/2013. Documentation did not contain the required elements on 7/27 and 28. Documentation received accounted for 27 units. One or more of the following elements was not met:
  - No documentation found. Only Substitute Care documentation provided.

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**Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007**

**CHAPTER 1 I. 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.


**CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES**

B. Reimbursement for Family Living Services

(1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year.

(2) Billable Activities shall include:
   a. Direct support provided to an individual in the residence any portion of the day;
   b. Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and
   c. Any other activities provided in accordance with the Scope of Services.

(3) Non-Billable Activities shall include:
   a. The Family Living Services Provider Agency may not bill the for room and board;
   b. Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and
   c. Family Living services may not be billed for the same time period as Respite.
   d. The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one July 2013

- The Agency billed 29 units of Family Living (T2033) from 7/1/2013 through 7/29/2013. Documentation did not contain the required elements on 7/19/2013. Documentation received accounted for 28 units. One or more of the following elements was not met:
  - The signature or authenticated name of staff providing the service.
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - Chapter 6 - COMMUNITY LIVING SERVICES

III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES

C. Service Limitations. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore, a specified deduction to the daily rate for Family Living shall be made for each unit of respite received.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - DEFINITIONS

SUBSTITUTE CARE means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider.

RESPITE means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.
Date: January 13, 2014

To: Hector Johnson, Assistant Executive Director
Provider: Community Options, Inc.
Address: 2500 Missouri Ave.
State/Zip: Las Cruces, New Mexico 88011
E-mail Address: hector.johnson@comop.org

CC: Robert Stack, Board Chair
Address: 16 Farber Rd.
State/Zip: Princeton, New Jersey 08540
Board Chair: Robert.Stack@comop.org

Region: Southwest
Survey Date: September 3 - 5, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living, Family Living) and Community Inclusion Supports (Adult Habilitation, Supported Employment)
Survey Type: Routine

Dear Mr. Johnson;

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
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.14.3.DDW.D3124.3.001.RTN.09.013