Dear Ms. Bilodeau;

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 505-231-7436 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Tony Fragua, BFA

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


Survey Report #: Q.14.2/DDW.D0664.1.001.RTN.01.042
Survey Process Employed:

Entrance Conference Date: December 9, 2013

Present:

Disability Services, Inc.
Ellen Bilodeau, Executive Director
Jennifer Lee, Business & Human Resource Manager
Greory Mitchell, RN
Yolanna Eriacho, Service Coordinator
Kim Wolowski, Service Coordinator
Jeffery Gama-Lobo, Program Director

DOH/DHI/QMB
Tony Fragua, BFA, Team Lead/Healthcare Surveyor
Erica Nilsen, BA, Healthcare Surveyor
Nicole Brown, MBA, Healthcare Surveyor

Exit Conference Date: December 11, 2013

Present:

Disability Services, Inc.
Ellen Bilodeau, Executive Director
Jennifer Lee, Business/Human Resource Manager
William Ratterman, RN
Yolanna Eriacho, Service Coordinator
Kim Wolowski, Service Coordinator
Patrick Chee, Independent Living Manager
Calsey Cowboy, Operations Manager
Jeffery Gama-Lobo, Program Director
Gregory Mitchell, RN

DOH/DHI/QMB
Tony Fragua, BFA, Team Lead/Healthcare Surveyor
Nicole Brown, MBA, Healthcare Surveyor
Erica Nilsen, BA, Healthcare Surveyor

DDSD - Northwest Regional Office
Dennis Okeefe, Social & Community Service Coordinator
Crystal Wright, Northwest Regional Manager

Administrative Locations Visited
Number: 1

Total Sample Size
Number: 7

- 4 - Jackson Class Members
- 3 - Non-Jackson Class Members
- 5 - Supported Living
- 2 - Independent Living
- 6 - Adult Habilitation
- 7 - Community Access
- 5 - Supported Employment

Total Homes Visited
Number: 4

- Supported Living Homes Visited
Number: 4
Persons Served Records Reviewed Number: 7
Persons Served Interviewed Number: 7
Direct Support Personnel Interviewed Number: 7
Direct Support Personnel Records Reviewed Number: 43
Substitute Care/Respite Personnel Records Reviewed Number: 7
Service Coordinator Records Reviewed Number: 2

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 deficiencies and non-compliance.

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

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 505-231-7436 or email at Anthony.Fragua@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

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

Instructions for Completing Agency POC:

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

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

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

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

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

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

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.

2. For questions about the POC process, call the POC Coordinator, Anthony Fragua at 505-231-7436 for assistance.

3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.

4. Submit your POC to Crystal Lopez-Beck, Deputy Bureau Chief in any of the following ways:
   a. Electronically at crystal.lopez-beck@state.nm.us (preferred method)
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Avenue NE, Suite 400, Albuquerque, NM 87108

5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”
   a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
   b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
   c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
   d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
   e. Please note that all POC correspondence will be sent electronically unless otherwise requested.

7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

**POC Document Submission Requirements**

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

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

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

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

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and 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**: Individuals have the right to live and work in a safe environment.

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

Compliance with Conditions of Participation
The QMB determination of Compliance with Conditions of Participation indicates that a provider is in compliance with all Conditions of Participation, (CoP). The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation in all relevant Service Domains. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) out of compliance in any of the Service Domains.

Partial-Compliance with Conditions of Participation
The QMB determination of Partial-Compliance with Conditions of Participation indicates that a provider is out of compliance with Conditions of Participation in one (1) to two (2) Service Domains. The agency may have one or more Condition level tags within a Service Domain. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains.

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

Non-Compliance with Conditions of Participation
The QMB determination of Non-Compliance with Conditions of Participation indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains.

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

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

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

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief within 10 business days of receipt of the final Report of Findings.
2. The written request for an IRF must be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: http://dhi.health.state.nm.us/qmb
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRC process, email the IRF Chairperson, 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>
</tr>
</thead>
<tbody>
<tr>
<td>Service Domain: Service Plans: ISP Implementation</td>
<td>Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</td>
</tr>
<tr>
<td>Tag # 1A08 Agency Case File</td>
<td>Standard Level Deficiency</td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service</td>
<td>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 7 individuals.</td>
</tr>
<tr>
<td>Standards effective 4/1/2007</td>
<td>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</td>
<td>• ISP Signature Page (#1, 3, 5)</td>
</tr>
<tr>
<td>The objective of these standards is to establish</td>
<td>• Positive Behavioral Plan (#3)</td>
</tr>
<tr>
<td>Provider Agency policy, procedure and reporting</td>
<td>• Positive Behavioral Crisis Plan (#3)</td>
</tr>
<tr>
<td>requirements for DD Medicaid Waiver program.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>These requirements apply to all such Provider</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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<tr>
<td>Agency staff, whether directly employed or</td>
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<tr>
<td>subcontracting with the Provider Agency.</td>
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<tr>
<td>Additional Provider Agency requirements and</td>
<td></td>
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<tr>
<td>personnel qualifications may be applicable for</td>
<td></td>
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<tr>
<td>specific service standards.</td>
<td></td>
</tr>
<tr>
<td>D. Provider Agency Case File for the Individual:</td>
<td></td>
</tr>
<tr>
<td>All Provider Agencies shall maintain at the</td>
<td></td>
</tr>
<tr>
<td>administrative office a confidential case file for</td>
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<tr>
<td>each individual. Case records belong to the</td>
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<tr>
<td>individual receiving services and copies shall be</td>
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<tr>
<td>provided to the receiving agency whenever an</td>
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<tr>
<td>individual changes providers. The record must also</td>
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<tr>
<td>be made available for review when requested by DOH,</td>
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<tr>
<td>HSD or federal government representatives for</td>
<td></td>
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<tr>
<td>oversight purposes. The individual’s case file</td>
<td></td>
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<tr>
<td>shall include the following requirements:</td>
<td></td>
</tr>
<tr>
<td>(1) Emergency contact information, including the</td>
<td></td>
</tr>
</tbody>
</table>
(1) The individual’s address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician’s name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;

(2) The individual’s complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);

(3) Progress notes and other service delivery documentation;

(4) Crisis Prevention/Intervention Plans, if there are any for the individual;

(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;

(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and

(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.

(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:

(a) Complete file for the past 12 months;
(b) ISP and quarterly reports from the current and prior ISP year;
(c) Intake information from original admission to services; and
(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
<table>
<thead>
<tr>
<th>Tag # 1A08.1</th>
<th>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 3 of 7 Individuals. Review of the Agency individual case files revealed the following items were not found:</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
</tbody>
</table>
| **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. | **Community Access Progress Notes/Daily Contact Logs**  
- Individual #3 - None found for 10/4/2013.  
- Individual #6 - None found for 10/2/2013.  
- Individual #7 - None found for 8/2/2013; 10/2 – 3, 2013. | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
<p>| <strong>D. Provider Agency Case File for the Individual:</strong> 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: | (3) Progress notes and other service delivery documentation; | |
| <strong>(3) Progress notes and other service delivery documentation;</strong> | | |</p>
<table>
<thead>
<tr>
<th>Tag # 1A32 and 6L14</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
<th>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Service Plan Implementation</strong></td>
<td>Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP.</strong> The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</td>
<td>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
<td></td>
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<tr>
<td>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</td>
<td><strong>Administrative Files Reviewed:</strong> Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. The intent is to provide choice and obtain</td>
<td><strong>Individual #2</strong></td>
<td><strong>Individual#3</strong></td>
<td></td>
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<tr>
<td></td>
<td>• According to the Live Outcome; Action Steps for &quot;With staff assistance ... will price check and choose the subject of his choice&quot; is to be completed 1 time per month evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2013 &amp; 10/2013.</td>
<td>• According to the Live Outcome; Action Steps for &quot;... will price check item(s) wanting to purchase&quot; is to be completed 1 time quarterly evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2013 - 3/2013 and 8/2013 – 10/2013.</td>
<td>• According to the Live Outcome; Action Steps for &quot;... will manage her money monthly&quot; is to be completed 1 time monthly</td>
</tr>
</tbody>
</table>
opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]

| Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2013 - 4/2013; 6/2013 and 8/2013 – 10/2013. |
|---|---|
| **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** |
| Individual #1 |
| • No Outcomes or DDSD exemption/decision justification found for Adult Habilitation Services. As indicated by NMAC 7.26.5.14 “Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.” |
| Individual #2 |
| • No Outcomes or DDSD exemption/decision justification found for Adult Habilitation Services. As indicated by NMAC 7.26.5.14 “Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.” |
| Individual #3 |
| • No Outcomes or DDSD exemption/decision justification found for Adult Habilitation Services. As indicated by NMAC 7.26.5.14 “Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.” |
| **Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** |
| Individual #2 |
According to the Fun Outcome; Action Steps for “With staff assistance … will research the event of his choice” is to be completed 1 times per month evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2013 and 9/2013.

Individual #3

According to the Fun Outcome; Action Steps for “… will manage her money” is to be completed 1 times per month evidence found indicated it was not being completed at the required frequency as indicated in the Agency’s Data collection documentation for 9/2013 and 10/2013.

According to the Fun Outcome; Action Steps for “… determine location and date to go shopping” is to be completed 1 times per month evidence found indicated it was not being completed at the required frequency as indicated in the Agency’s Data collection documentation for 9/2013 and 10/2013.
<table>
<thead>
<tr>
<th>Tag # 6L14 Residential Case File</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tag # 6L14 Residential Case File</td>
<td>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 3 of 5 Individuals receiving Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</td>
<td><strong>A. Residence Case File:</strong> 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:</td>
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<td>(1) Complete and current ISP and all supplemental plans specific to the individual;</td>
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<td></td>
<td>(2) Complete and current Health Assessment Tool;</td>
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<td></td>
<td>(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;</td>
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<td>(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);</td>
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<td></td>
<td>(5) Data collected to document ISP Action Plan implementation</td>
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<tr>
<td></td>
<td><strong>Medical Emergency Response Plans</strong></td>
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<tr>
<td></td>
<td>- Aspiration (#5)</td>
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<td></td>
<td>- Osteoporosis (#5)</td>
<td></td>
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<td></td>
<td>- Unplanned Weight Loss (#2)</td>
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<tr>
<td></td>
<td><strong>Positive Behavioral Plan</strong> (#3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Positive Behavioral Crisis Plan</strong> (#3)</td>
<td></td>
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<td></td>
<td><strong>Occupational Therapy Plan</strong> (#5)</td>
<td></td>
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<tr>
<td></td>
<td><strong>Physical Therapy Plan</strong> (#2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</table>
(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;
(7) Physician’s or qualified health care providers written orders;
(8) Progress notes documenting implementation of a physician’s or qualified health care provider’s order(s);
(9) Medication Administration Record (MAR) for the past three (3) months which includes:
   (a) The name of the individual;
   (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;
   (c) Diagnosis for which the medication is prescribed;
   (d) Dosage, frequency and method/route of delivery;
   (e) Times and dates of delivery;
   (f) Initials of person administering or assisting with medication; and
   (g) An explanation of any medication irregularity, allergic reaction or adverse effect.
   (h) For PRN medication an explanation for the use of the PRN must include:
      (i) Observable signs/symptoms or circumstances in which the medication is to be used, and
      (ii) Documentation of the effectiveness/result of the PRN delivered.
   (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual’s home and an updated
copy must be placed in the agency file on a weekly basis.

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

(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.
<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>

**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 # 1A36 Service Coordination Requirements</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
<th></th>
</tr>
</thead>
</table>
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and **NMAC 7.26.5.7 “service coordinator”: the** | Based on record review, the Agency did not ensure that Orientation and Training requirements were met for 1 of 2 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:  
• Health Wellness Coordination (SC #83) |...
community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency

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

(i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;
(ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;
(iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;
(iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;
### 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.

<table>
<thead>
<tr>
<th>Tag # 1A05</th>
<th>Standard of Care</th>
</tr>
</thead>
</table>

*CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:* The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.

### A. General Requirements:

(2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.


<table>
<thead>
<tr>
<th>Tag # 1A05</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>General Provider Requirements</td>
<td>Based on record review, the Agency did not develop, implement and/or update written policies and procedures that comply with all DDSD policies and procedures. Review of Agency policies and procedures found the following: <strong>The following policies and procedures showed no evidence of being reviewed every three years or being updated as needed:</strong></td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here:</td>
<td></td>
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<tr>
<td>Tag # 1A09</td>
<td>Standard Level Deficiency</td>
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<tr>
<td>Routine Medication Administration</td>
<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></td>
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</tr>
<tr>
<td>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</td>
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<td>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</td>
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<td></td>
<td>(a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;</td>
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<td>(b) Prescribed dosage, frequency and method/route of administration, times</td>
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<td></td>
<td>Medication Administration Records (MAR) were reviewed for the months of September, October and December 2013.</td>
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<tr>
<td></td>
<td>Based on record review, 3 of 5 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</td>
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<tr>
<td></td>
<td>Individual #1 September 2013 Medication Administration Records contain the following medications:</td>
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<tr>
<td></td>
<td>• Metamucil Powder 3.4 mg (1 time daily)</td>
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<tr>
<td></td>
<td>October 2013 Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Metamucil Powder 3.4 mg (1 time daily)</td>
<td></td>
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<td></td>
<td>Individual #2 September 2013 Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:</td>
<td></td>
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<tr>
<td></td>
<td>• Calcium Antacid 500mg (3 times daily)</td>
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<tr>
<td></td>
<td>October 2013 Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:</td>
<td></td>
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<td></td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
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</tr>
<tr>
<td></td>
<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>
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 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:

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

- Calcium Antacid 500mg (3 times daily)

December 2013
Medication Administration Records did not contain the diagnosis for which the medication is prescribed:
- Docusate 50mg/5ml (2 times daily)

Individual #3
September 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
- Levothyroxine 100mcg (1 time daily)

October 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
- Levothyroxine 100mcg (1 time daily)

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Oyster Shell 500mg (2 times daily) – Blank 10/23 (10 PM)
(ii) Date given;
(iii) Drug product name;
(iv) Dosage and form;
(v) Strength of drug;
(vi) Route of administration;
(vii) How often medication is to be taken;
(viii) Time taken and staff initials;
(ix) Dates when the medication is
   discontinued or changed;
(x) The name and initials of all staff
    administering medications.

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

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

- symptoms that indicate the use of the
  medication,
- exact dosage to be used, and
- the exact amount to be used in a 24
  hour period.
<table>
<thead>
<tr>
<th>Tag # 1A15.2 and 5I09 Healthcare Documentation</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 <strong>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:</strong> Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</td>
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<tr>
<td>Based on record review, the Agency did not maintain the required documentation in the Individual’s Agency Record as required by standard for 4 of 7 individuals.</td>
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<tr>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
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<tr>
<td><strong>Quarterly Nursing Review of HCP/Medical Emergency Response Plans:</strong></td>
<td></td>
</tr>
<tr>
<td>- None found for 10/2012 - 3/2013 (#1)</td>
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<tr>
<td>- None found for 4/2013 - 9/2013 (#4)</td>
<td></td>
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<tr>
<td><strong>Health Care Plans</strong></td>
<td></td>
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<tr>
<td>- <strong>Fixed Deformity</strong></td>
<td></td>
</tr>
<tr>
<td>Individual #5 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.</td>
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<tr>
<td><strong>Medical Emergency Response Plans</strong></td>
<td></td>
</tr>
<tr>
<td>- <strong>Unplanned Weight Loss</strong></td>
<td></td>
</tr>
<tr>
<td>Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.</td>
<td></td>
</tr>
<tr>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</table>

**Provider:**

**Description:**

Provider:

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

Provider:
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,
method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

(2) Health related plans

(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately 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 # 1A27</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident Mgt. Late and Failure to Report</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: A. Duty To Report:

1. All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.
2. All community based service providers shall report to the division within twenty four (24) hours:
   - abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:
     - an environmental hazardous condition, which creates an immediate threat to life or health; or
     - admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.
3. All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.

#### B. Notification: (1) Incident Reporting:

- Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division’s incident report form. The incident report form and instructions for the completion and filing are available at the division’s website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.

Based on the Incident Management Bureau’s Late and Failure Reports, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 1 of 8 individuals.

**Individual #8**
- Incident date 11/16/2013. Allegation was Emergency Services. Incident report was received 11/19/2013. IMB issued a Late Reporting for Emergency Services.

**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: →

<table>
<thead>
<tr>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tag # 1A27.2</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td><strong>IRs Filed During On-Site and/or IRs Not Reported by Provider</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 7 Individuals.</td>
</tr>
</tbody>
</table>

During the on-site survey December 9 – 11, 2013, surveyors found evidence of 1 internal agency incident report, which had not been reported to DHI and/or APS/CYFD, as required by regulation.

The following internal incident was reported as a result of the on-site survey:

**Individual #3**
- Incident date 8/4/2013 (3:19 PM). Type of incident identified was Emergency Services. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 12/13/2013 by DHI/QMB and the Agency.

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

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
to the division by telephone call, written
 correspondence or other forms of
 communication utilizing the division’s incident
 report form. The incident report form and
 instructions for the completion and filing are
 available at the division’s website;
 http://dhi.health.state.nm.us/elibrary/ironline/ir.p
 hp or may be obtained from the department by
 calling the toll free number.

(2) Division Incident Report Form and
 Notification by Community Based Service
 Providers: The community based service
 provider shall report incidents utilizing the
 division’s incident report form consistent with
 the requirements of the division’s incident
 management system guide. The community
 based service provider shall ensure all incident
 report forms alleging abuse, neglect or
 misappropriation of consumer property
 submitted by a reporter with direct knowledge
 of an incident are completed on the division’s
 incident report form and received by the
 division within twenty-four (24) hours of an
 incident or allegation of an incident or the next
 business day if the incident occurs on a
 weekend or a holiday. The community based
 service provider shall ensure that the reporter
 with the most direct knowledge of the incident
 prepares the incident report form.
<table>
<thead>
<tr>
<th>Tag # 1A31</th>
<th>Client Rights/Human Rights</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Rights/Human Rights</td>
<td>Standard Level Deficiency</td>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT’S RIGHTS:</td>
<td>Based on record review, the Agency did not ensure the rights of Individuals was not restricted or limited for 1 of 1 Individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>A. A service provider shall not restrict or limit a client's rights except:</td>
<td>A review of Agency Individual files found no documentation of Positive Behavior Plans and/or Positive Behavior Crisis Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (#3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or</td>
<td>No documentation was found regarding Human Rights Approval on a quarterly basis for the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</td>
<td>- Positive Behavior Support Plan “Restitution plan for damaged property.” (Individual #3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</td>
<td>- Positive Behavior Crisis Plan “In Crisis (Suicidal thoughts), remove sharps, keep in line of sight, bedroom door open to monitor ADL’s, no phone use and no visitors.” (Individual #3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider’s behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.</td>
<td>Last Human Rights Committee meeting dated 12/20/2012.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Long Term Services Division**

**Policy Title:** Human Rights Committee
**Requirements Eff Date: March 1, 2003**

**IV. POLICY STATEMENT - Human Rights**

Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

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

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

**A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS**

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

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

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

Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006

B. 1. e. If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).
<table>
<thead>
<tr>
<th>Tag #</th>
<th>6L25</th>
<th>Residential Health and Safety (SL/FL)</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
</table>
| | **Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007**  
**CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS**  
L. Residence Requirements for Family Living Services and Supported Living Services  
(1) Supported Living Services and Family Living Services providers shall assure that each individual’s residence has:  
(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;  
(b) General-purpose first aid kit;  
(c) When applicable due to an individual’s health status, a blood borne pathogens kit;  
(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;  
(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;  
(f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;  
(g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP; and  
(h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. | Based on observation, the Agency did not ensure that each individuals’ residence met all requirements within the standard for 2 of 4 Supported Living.  
Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:  
**Supported Living Requirements:**  
- Accessible 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 (#3, 4) | State your Plan of Correction for the deficiencies cited in this tag here: → |
| | **Provider:**  
**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:** → |
### Standard of Care: 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 # 5I36
Community Access Reimbursement

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Community Access Services for 6 of 7 individuals.</td>
<td></td>
</tr>
<tr>
<td>Individual #1 September 2013</td>
<td></td>
</tr>
<tr>
<td>- The Agency billed 53 units of Community Access (H22021 U1) from 9/20/2013 through 9/22/2013. Documentation received accounted for 51 units.</td>
<td></td>
</tr>
<tr>
<td>October 2013</td>
<td></td>
</tr>
<tr>
<td>- The Agency billed 32 units of Community Access (H22021 U1) on 10/5/2013. Documentation received accounted for 36 units.</td>
<td></td>
</tr>
<tr>
<td>Individual #2 August 2013</td>
<td></td>
</tr>
<tr>
<td>- The Agency billed 48 units of Community Access (H22021 U1) from 8/7/2013 through 8/9/2013. Documentation received accounted for 42 units.</td>
<td></td>
</tr>
<tr>
<td>Individual #3 October 2013</td>
<td></td>
</tr>
<tr>
<td>- The Agency billed 4 units of Community Access (H2201 U1) on 10/4/2013. Documentation did not contain the required elements on 10/4/2013. Documentation received accounted for 0 units. One or more of the following elements was not met:</td>
<td></td>
</tr>
</tbody>
</table>

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

### 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 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS

G. Reimbursement

(1) Billable Unit: A billable unit is defined as one-quarter hour of service.

(2) Billable Activities: The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions:

(a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan;
(b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and
(c) Non face-to-face hours do not exceed 10% of the monthly billable hours.

(3) Non-Billable Activities: Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:

(a) Time and expense for training service personnel;
(b) Supervision of agency staff;
(c) Service documentation and billing activities; or
(d) Time the individual spends in segregated facility-based settings activities.

No documentation found.

Individual #5
August 2013
- The Agency billed 12 units of Community Access (H2021 U1) on 8/22/2013. Documentation received accounted for 2 units.

Individual #6
October 2013
- The Agency billed 2 units of Community Access (H2021 U1) on 10/2/2013. Documentation did not contain the required elements on 10/2/2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - No documentation found.

Individual #7
August 2013
- The Agency billed 32 units of Community Access (H2021 U1) on 8/1/2013 through 8/2/2013. Documentation did not contain the required elements on 8/2/2013. Documentation received accounted for 24 units. One or more of the following elements was not met:
  - No documentation found.

October 2013
- The Agency billed 6 units of Community Access (H2021 U1) on 10/2/2013 through 10/3/2013. Documentation did not contain the required elements on 10/2, 3. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - No documentation found.
<table>
<thead>
<tr>
<th>Tag # 5144</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Habilitation Reimbursement</strong></td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 2 of 6 individuals.</td>
</tr>
</tbody>
</table>
| **Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007** | Individual #2 September 2013  
- The Agency billed 32 units of Adult Habilitation (T2021 U1) from 9/10/2013 through 9/12/2013. Documentation received accounted for 17 units. |
| **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** | Individual #3 October 2013  
- The Agency billed 56 units of Adult Habilitation (T2021 U2) from 10/7/2013 through 10/12/2013. Documentation received accounted for 50 units. |
| **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. | **Provider:**  
State your Plan of Correction for the deficiencies cited in this tag here: → |
| **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. | **Provider:**  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |

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 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.
<table>
<thead>
<tr>
<th>Tag # 6L28</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent Living Reimbursement</strong></td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Independent Living Services for 1 of 2 individuals.</td>
</tr>
</tbody>
</table>

Individual #6  
September 2013  
- The Agency billed 1 unit of Independent Living (T2030) from 9/1/2013 through 9/30/2013. As indicated by the Individual’s budget the individual is to receive Regular (no less than 20 hours) Independent Living. Documentation received accounted for 14.75 hours, which is less than the required amount.

<table>
<thead>
<tr>
<th>Provider:</th>
<th>State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
</table>

**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

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

CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES
D. Reimbursement for Independent Living Services: The billable unit for Independent Living Services is a monthly rate with a maximum of 12 units a year. Independent Living Services is reimbursed at two levels based on the number of hours of service needed by the individual as specified in the ISP. An individual receiving at least 20 hours but less than 100 hours of direct service per month will be reimbursed at Level II rate. An individual receiving 100 or more hours of direct service per month will be reimbursed at the Level I rate.
Date: June 6, 2014

To: Ellen Bilodeau, Executive Director
Provider: Disability Services, Inc.
Address: P.O. Box 1296
State/Zip: Gallup, New Mexico 87305
E-mail Address: Ellenbilodeau@gmail.com

CC: Jennifer Lee, Business & Human Resources Manager
E-mail Address: jenniferlynnlee@hotmail.com

Region: Northwest
Survey Date: December 9 - 11, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living, Independent Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)
Survey Type: Routine

Dear Ms. Bilodeau:

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.**

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

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

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

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

Sincerely,

Crystal Lopez-Beck
Deputy Bureau Chief
Quality Management Bureau/DHI