



Date: August 25, 2011

To: Mary Best, Executive Director  
 Provider: Goodwill Industries of New Mexico  
 Address: 5000 San Mateo NE  
 State/Zip: Albuquerque, New Mexico 87109

E-mail Address: [mbest@goodwillnm.org](mailto:mbest@goodwillnm.org)

CC: Valerie McGlasson, Director Workforce Development  
 Address: 5000 San Mateo NE  
 State/Zip: Albuquerque, New Mexico 87109

Board Chair  
 E-Mail Address: [vmcglasson@goodwillnm.org](mailto:vmcglasson@goodwillnm.org)

Region: Metro & NW Region  
 Survey Date: July 12 – 18, 2011  
 Program Surveyed: Developmental Disabilities Waiver  
 Service Surveyed: Community Inclusion (Supported Employment)  
 Survey Type: Routine  
 Team Leader: Crystal Lopez-Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
 Team Members: Maurice Gonzales, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Sean Sarver, Developmental Disabilities Supports Division & Kathy H. Johnson, Developmental Disabilities Supports Division

Dear Ms. Best;

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 contracts. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

**Quality Management Compliance Determination:**

The Division of Health Improvement is issuing your agency a determination of “Substandard Compliance with Conditions of Participation.”

**Plan of Correction:**



**Division of Health Improvement • Quality Management Bureau**  
 5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108  
 (505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

QMB Report of Findings –Goodwill Industries of New Mexico – Metro & Northwest Regions – July 12 – 18, 2011

The attached Report of Findings identifies deficiencies found during your agency's compliance review. You are required to complete and implement a 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. The response is due to the parties below within 10 business days of the receipt of this letter:

- 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 within 45 business days. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as all remedies must still be completed within 45 business days of the receipt of this letter.

Failure to submit, complete or implement your Plan of Correction within the 45 day required time frames 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 business days. Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator at 505-222-8647 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

*Crystal Lopez-Beck, BA*

Crystal Lopez-Beck, BA  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: July 12, 2011

Present: **Goodwill Industries of New Mexico**  
Valerie McGlasson, Director Workforce Development  
Dan Kenaley, Program Manager

**DOH/DHI/QMB**  
Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor  
Maurice Gonzales, BS, Healthcare Surveyor

**DDSD - Metro Regional Office**  
Sean Sarver, Supported Employment Specialist

Exit Conference Date: July 14, 2011

Present: **Goodwill Industries of New Mexico**  
Valerie McGlasson, Director Workforce Development  
Dan Kenaley, Program Manager  
Bill Kesatie, Communities Program Manager

**DOH/DHI/QMB**  
Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor  
Maurice Gonzales, BS, Healthcare Surveyor

**DDSD - Metro Regional Office**  
Sean Sarver, Supported Employment Specialist

Administrative Locations Visited Number: 1

Total Sample Size Number: 12  
1 - *Jackson* Class Members  
11 - Non-*Jackson* Class Members  
12 - Supported Employment

Persons Served Interviewed Number: 2

Persons Served Observed Number: 10 Individuals were unavailable as they were performing their job duties during the on-site survey

Person Served Records Reviewed Number: 12

Direct Service Professionals Interviewed Number: 6

Direct Service Professionals Record Review Number: 13

Service Coordinator Record Review Number: 2

Administrative Files Reviewed

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

- Evacuation Drills
- Quality Assurance / Improvement Plan

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

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

### **Introduction:**

After a QMB Compliance Review, your QMB Report of Findings will be sent to you via US mail.

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

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

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-222-8647 or email at [George.Perrault@state.nm.us](mailto:George.Perrault@state.nm.us) Requests for technical assistance must be requested through your DDS Regional Office.

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) days of receiving your report. The POC process cannot resolve disputes regarding findings. 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. (see page 3, DDW standards, effective; April 1, 2007, Chapter 1, Section I Continuous Quality Management System)

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 you submit needs to address **each deficiency** in the two right hand columns with:

1. How the corrective action will be accomplished for all cited deficiencies in the report of findings;
2. How your Agency will identify all other individuals having the potential to be affected by the same deficient practice;
3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur and corrective action is sustained;
4. How your Agency plans to monitor corrective actions utilizing its continuous Quality Assurance/Quality Improvement Plan to assure solutions in the plan of correction are achieved and sustained, including (if appropriate):
  - Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
  - Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
  - Your processes for ensuring that all staff are trained in Core Competencies, Incident Reporting, and Individual-Specific service requirements, etc;
  - How accuracy in Billing documentation is assured;

- How health, safety is assured;
  - For Case Management Providers, how ISPs are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
  - Your process for gathering, analyzing and responding to Quality data, and
  - Details about Quality Targets in various areas, current status, Root Cause Analyses about why Targets were not met, and remedies implemented.
5. The individual's title responsible for the Plan of Correction and completion date.

**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). Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 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.

### **Plan of Correction Submission Requirements**

1. Your 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. If you have questions about the POC process, call the POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
  - a. Electronically at [George.Perrault@state.nm.us](mailto:George.Perrault@state.nm.us)
  - b. Faxed to 505-222-8661, or
  - c. Mailed to QMB, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not send supporting documentation to QMB until after your POC has been approved by QMB.
6. QMB will notify you when your POC has been "approve" or "denied."
  - a. 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 that your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 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.
8. Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

### ***POC Document Submission Requirements***

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

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. You may submit your documents by postal mail, fax, or electronically on disc or 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; hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. For billing deficiencies, you must submit:
  - a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
  - b. Copies of "void and adjust" forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

## QMB Scope and Severity Matrix

Each deficiency in your Report of Findings is scored on a Scope and Severity Scale. The culmination of each deficiency's Scope and Severity is used to determine degree of compliance to standards and regulations and level of QMB Compliance Determination.

		SCOPE			
		Isolated 01% - 15%	Pattern 16% - 79%	Widespread 80% - 100%	
SEVERITY	High Impact	Immediate Jeopardy to individual health and or safety	J.	K.	L.
		Actual harm	G.	H.	I.
	Medium Impact	No Actual Harm Potential for more than minimal harm	D.	E.	F. (3 or more)
			D. (2 or less)		F. (no conditions of participation)
	Low Impact	No Actual Harm Minimal potential for harm.	A.	B.	C.

### Scope and Severity Definitions:

- **Isolated:**  
A deficiency that is limited to 1% to 15% of the sample, usually impacting few individuals in the sample.
  
- **Pattern:**  
A deficiency that impacts a number or group of individuals from 16% to 79% of the sample is defined as a pattern finding. Pattern findings suggest the need for system wide corrective actions.
  
- **Widespread:**  
A deficiency that impacts most or all (80% to 100%) of the individuals in the sample is defined as widespread or pervasive. Widespread findings suggest the need for system wide corrective actions as well as the need to implement a Continuous Quality Improvement process to improve or build infrastructure. Widespread findings could be referred to the Internal Review Committee for review and possible actions or sanctions.



## QMB Determinations of Compliance

- “Substantial Compliance with Conditions of Participation”

The QMB determination of “Substantial Compliance with Conditions of Participation” indicates that a provider is in substantial compliance with all ‘Conditions of Participation’ and other standards and regulations. 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 Substantial Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation.

- “Non-Compliance with Conditions of Participation”

The QMB determination of “Non-Compliance with Conditions of Participation” indicates that a provider is out of compliance with one (1) or more ‘Conditions of Participation.’ This non-compliance, if not corrected, is likely to result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety.

Providers receiving a repeat determination of ‘Non-Compliance’ may be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- “Sub-Standard Compliance with Conditions of Participation”:

The QMB determination of “Sub-Standard Compliance with Conditions of Participation” indicates a provider is significantly out of compliance with Conditions of Participation and/or has:

- Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
- Any finding of actual harm or Immediate Jeopardy.

Providers receiving a repeat determination of ‘Substandard Compliance’ will be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

## **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 that surveyors have clarified issues and/or requested missing information before completing the review. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

### **Instructions:**

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.
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.

### **The following limitations apply to the IRF process:**

- The request for an IRF and all supporting evidence must be received within 10 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 QMB compliance determination or the length of their DDS provider contract.

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

QMB has 30 working days to complete the review and notify the provider of the decision. The request will be reviewed by the IRF committee. The Provider will be notified in writing of the ruling; no face to face meeting will be conducted.

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

**Agency:** Goodwill Industries of New Mexico – Metro & Northwest Regions  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Inclusion (Supported Employment)  
**Monitoring Type:** Routine Survey  
**Date of Survey:** July 12 – 18, 2011

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<b>Tag # 1A03 CQI System</b>	<b>Scope and Severity Rating: C</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS</b></p> <p><b>I. Continuous Quality Management System:</b>            Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider’s service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to:</p> <ol style="list-style-type: none"> <li>(1) Individual access to needed services and supports;</li> <li>(2) Effectiveness and timeliness of implementation of Individualized Service Plans;</li> <li>(3) Trends in achievement of individual outcomes in the Individual Service Plans;</li> <li>(4) Trends in medication and medical incidents leading to adverse health events;</li> <li>(5) Trends in the adequacy of planning and coordination of healthcare supports at both</li> </ol>	<p>Based on record review and interview, the Agency failed to develop and implement a Continuous Quality Management System.</p> <p>Review of the Agency’s records found no evidence of a CQI Plan.</p> <p>When #57 was asked for a copy of the Agency’s Continuous Quality Improvement System, a copy of Goodwill Industries CARF Accreditation Plan of Correction was provided. When asked if the agency had an ongoing Quality Improvement/Quality Assurance Plan that was not a response to a CARF survey, the following was reported:</p> <ul style="list-style-type: none"> <li>• #57 stated, “No, that is all we have.”</li> </ul>	<p><u>Provider:</u>            Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>	

- supervisory and direct support levels;
- (6) Quality and completeness documentation; and
- (7) Trends in individual and guardian satisfaction.

**7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:**

**E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:

- (1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;
- (2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;
- (4) community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.

Tag # 1A05 (CoP) General Requirements	Scope and Severity Rating: F	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> 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.</p> <p><b>A. General Requirements:</b></p> <p>(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 DDS 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.</p>	<p>Based on record review, the Agency failed to develop and implement written policies and procedures that comply with all DDS policies and procedures.</p> <p>Review of Agency policies &amp; procedures found no evidence of the following:</p> <ul style="list-style-type: none"> <li>• Policy &amp; Procedure for an on-call system that includes nursing on-call procedures</li> </ul>	<p>Provider: Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

Tag # 1A07 SSI Payments	Scope and Severity Rating: C	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> 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.</p> <p>C. Provider Agency Financial Records and Accounting: Each individual served will be presumed able to manage his or her own funds unless the ISP documents justified limitations or supports for self-management, and where appropriate, reflects a plan to increase this skill. All Provider Agencies shall maintain and enforce written policies and procedures regarding the use of the individual's SSI payments or other personal funds, including accounting for all spending by the Provider Agency, and outlining protocols for fulfilling the responsibilities as representative payee if the agency is so designated for an individual.</p> <p><b>Code of Federal Regulations:</b></p> <p><b>§416.635 What are the responsibilities of your representative payee...</b></p> <p>A representative payee has a responsibility to:</p> <p>(a) Use the benefits received on your behalf only for your use and benefit in a manner and for the purposes he or she determines under the guidelines in this subpart, to be in your best interests;</p> <p>(b) Keep any benefits received on your behalf separate from his or her own funds and show your ownership of these benefits unless he or she is your spouse or natural or adoptive parent or stepparent</p>	<p>Based on record review and interview, the Agency failed to maintain and enforce written policies and procedures regarding the use of individuals' SSI payments or other personal funds.</p> <p>Review of the Agency's policies &amp; procedures found no evidence of a policy regarding individual SSI payments or other personal funds.</p> <p>When #55 &amp; 57 were asked if the Agency had policies and procedures regarding the use of individuals' SSI payments or other personal funds, the following was reported:</p> <p>#55 &amp; 57 stated, "We do not handle individuals funds, therefore do not have a policy. However, there is nothing in our policy and procedures that states we do not provide this service."</p>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

and lives in the same household with you or is a State or local government agency for whom we have granted an exception to this requirement;

(c) Treat any interest earned on the benefits as your property;

(d) Notify us of any event or change in your circumstances that will affect the amount of benefits you receive, your right to receive benefits, or how you receive them;

(e) Submit to us, upon our request, a written report accounting for the benefits received on your behalf, and make all supporting records available for review if requested by us;

(f) Notify us of any change in his or her circumstances that would affect performance of his/her payee responsibilities; and

§416.640 Use of benefit payments.

**Current maintenance.** We will consider that payments we certify to a representative payee have been used for the use and benefit of the beneficiary if they are used for the beneficiary's current maintenance. Current maintenance includes costs incurred in obtaining food, shelter, clothing, medical care and personal comfort items.

**§416.665 How does your representative payee account for the use of benefits...**

Your representative payee must account for the use of your benefits. We require written reports from your representative payee at least once a year (except for certain State institutions that participate in a separate onsite review program). We may verify how your representative payee used your benefits. Your representative payee should keep records of how benefits were used in order to make accounting reports and must make those records available upon our request.

Tag # 1A08 Agency Case File	Scope and Severity Rating: C	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> 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.</p> <p><b>D. Provider Agency Case File for the Individual:</b> 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:</p> <ol style="list-style-type: none"> <li>(1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;</li> <li>(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);</li> <li>(3) Progress notes and other service delivery documentation;</li> <li>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</li> <li>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the</li> </ol>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 11 of 12 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• <b>Current Emergency &amp; Personal Identification Information</b> <ul style="list-style-type: none"> <li>◦ Did not contain Pharmacy Information (#8)</li> </ul> </li> <li>• <b>Annual ISP</b> <ul style="list-style-type: none"> <li>◦ Not Current (#7)</li> </ul> </li> <li>• <b>ISP Signature Page (#7)</b></li> <li>• <b>ISP Teaching &amp; Support Strategies</b> <ul style="list-style-type: none"> <li>◦ Individual #3 - TASS not found for:</li> <li>◦ Outcome Statement WORK/LEARN <ul style="list-style-type: none"> <li>➢ Individual #3 "will attend relationship course in the community."</li> </ul> </li> <li>◦ Individual #7 - TASS not found for: <ul style="list-style-type: none"> <li>➢ Current Annual ISP 07/10/11 – 07/09/12</li> </ul> </li> <li>◦ Individual #10 - TASS not found for:</li> <li>◦ Outcome Statement # 2 <ul style="list-style-type: none"> <li>➢ Individual #10 "will learn and complete two job duties."</li> </ul> </li> </ul> </li> <li>• <b>Positive Behavioral Crisis Plan (#8)</b></li> <li>• <b>Speech Therapy Plan (#7)</b></li> <li>• <b>Occupational Therapy Plan (#7 &amp; 8)</b></li> <li>• <b>Annual Physical (#5, 6, 7 &amp; 8)</b></li> <li>• <b>Dental Exam</b></li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>



<p>developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(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</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p> <p><b>NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b> 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.</p> <p><b>B. Documentation of test results:</b> Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.</p>	<ul style="list-style-type: none"> <li>◦ Individual #4 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</li> <li>◦ Individual #5 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</li> <li>◦ Individual #6 - As indicated by collateral documentation reviewed, the exam was completed on 06/23/2011. No evidence of exam results were found.</li> <li>◦ Individual #7 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</li> <li>◦ Individual #9 - As indicated by collateral documentation reviewed, the exam was completed on 05/05/2010. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found.</li> <li>◦ Individual #11 - As indicated by collateral documentation reviewed, the exam was completed on 01/13/2009. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found.</li> <li>◦ Individual #12 - As indicated by collateral documentation reviewed, the exam was completed on 05/17/2010. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found.</li> </ul> <ul style="list-style-type: none"> <li>• <b>Vision Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #2 - As indicated by collateral documentation reviewed, the exam was completed on 01/06/2009. As indicated by the</li> </ul> </li> </ul>		
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	<p>DDSD file matrix Vision Exams are to be conducted every other year. No evidence of current exam was found.</p> <ul style="list-style-type: none"><li>◦ Individual #3 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</li><li>◦ Individual #4 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</li><li>◦ Individual #7 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</li></ul>		
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Tag # 1A08.1 Agency Case File - Progress Notes	Scope & Severity Rating: A	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> 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.</p> <p><b>D. Provider Agency Case File for the Individual:</b> 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:</p> <p>(3) Progress notes and other service delivery documentation;</p>	<p>Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 1 of 12 Individuals.</p> <p><b>Supported Employment Progress Notes/Daily Contact Logs</b></p> <ul style="list-style-type: none"> <li>Individual #5 - None found for 03/04/2011, 04/08/2011 &amp; 05/10/2011</li> </ul>	<p>Provider: Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

Tag # 1A11 (CoP) Transportation P&P	Scope and Severity Rating: F	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> 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.</p> <p><b>G. Transportation:</b> Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and procedures must address at least the following topics:</p> <ol style="list-style-type: none"> <li>(1) Drivers' requirements,</li> <li>(2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions,</li> <li>(3) Vehicle maintenance and safety inspections,</li> <li>(4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures,</li> <li>(5) Emergency Plans, including vehicle evacuation techniques,</li> <li>(6) Documentation, and</li> <li>(7) Accident Procedures.</li> </ol> <p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy</b>  Training Requirements for Direct Service Agency Staff Policy <b>Eff Date:</b> March 1, 2007</p>	<p>Based on record review and interview, the Agency failed to have a written policies and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals.</p> <p>Review of Agency's policies and procedures found no evidence of the Agency's transportation policy &amp; procedure.</p> <p><b>When #57 was asked if the Agency had a policy regarding the safe transportation of individuals, the following was reported:</b></p> <p>#57 stated, "We do not provide any type of transportation for our clients but currently do not have a policy that states this."</p>	<p><u>Provider:</u>  Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

**II. POLICY STATEMENTS:**

1. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:

1. Operating a fire extinguisher
2. Proper lifting procedures
3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat)
4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff's role)
6. Wheelchair tie-down procedures (if applicable to the staff's role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)

Tag # 1A15.1 Nurse Availability	Scope and Severity Rating: D	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007  <b>Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:</b> Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p><b>NEW MEXICO NURSING PRACTICE ACT CHAPTER 61, ARTICLE 3</b></p> <p>I. "licensed practical nursing" means the practice of a directed scope of nursing requiring basic knowledge of the biological, physical, social and behavioral sciences and nursing procedures, which practice is at the direction of a registered nurse, physician or dentist licensed to practice in this state. This practice includes but is not limited to:</p> <p>(1) contributing to the assessment of the health status of individuals, families and communities;  (2) participating in the development and modification of the plan of care;  (3) implementing appropriate aspects of the plan of care commensurate with education and verified competence;  (4) collaborating with other health care professionals in the management of health care; and  (5) participating in the evaluation of responses to interventions;</p>	<p>Based on interview, the Agency failed to ensure nursing services were available as needed for 2 of 12 individuals.</p> <p>When Direct Service Professional (DSP) were asked if there is a nurse available to the individual, the following was reported:</p> <ul style="list-style-type: none"> <li>• DSP #41 stated, "No, there is no nurse here." (Individuals #11 &amp; 12)</li> </ul>	<p>Provider:  Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

Tag # 1A15.2 & 5109 - Healthcare Documentation	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>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:</b> Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p><b>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</b></p> <p>(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:</p> <ul style="list-style-type: none"> <li>(i) Community living services provider agency;</li> <li>(ii) Private duty nursing provider agency;</li> <li>(iii) Adult habilitation provider agency;</li> <li>(iv) Community access provider agency; and</li> <li>(v) Supported employment provider agency.</li> </ul> <p>(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 8 of 12 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• Health Assessment Tool or Electronic Health Assessment Tool (E-Chat) (#1, 7, 9, 10 &amp; 12)</li> <li>• Medication Administration Assessment Tool (#1, 7, 8, 9, 10 &amp; 12)</li> <li>• Aspiration Risk Screening Tool (#4, 7, 8, 9 &amp; 12)</li> <li>• Comprehensive Aspiration Risk Management Tool (#7, 8, 9 &amp; 12)</li> <li>• <b>Health Care Plans</b> <ul style="list-style-type: none"> <li>• Seizures <ul style="list-style-type: none"> <li>◦ Individual #11 - As indicated by the IST section of ISP the individual is required to have a plan.</li> <li>◦ Individual #12 - According to documentation reviewed the individual is required to have a plan. Plan in file was not current.</li> </ul> </li> <li>• Bowel Function <ul style="list-style-type: none"> <li>◦ Individual #12 - According to documentation reviewed the individual is required to have a plan. Plan in file was not current.</li> </ul> </li> <li>• Medication Administration <ul style="list-style-type: none"> <li>◦ Individual #12 - According to documentation reviewed the individual is required to have a plan. Plan in file was not current.</li> </ul> </li> </ul> </li> <li>• Sexuality</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

<p>agency nurse must be available to assist the caregiver upon request.</p> <p>(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.</p> <p>(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 DDS Medication Assessment and Delivery Policy).</p> <p>(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 <i>subjective</i> information including the individual complaints, signs and symptoms noted by staff, family members or other team members; <i>objective</i> information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); <i>assessment</i> of the clinical status, and <i>plan</i> of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p><b>(2) Health related plans</b></p> <p>(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</p>	<ul style="list-style-type: none"> <li>◦ Individual #12 - According to documentation reviewed the individual is required to have a plan. Plan in file was not current.</li> <li>• Aggression/Physical Chemical Restraint <ul style="list-style-type: none"> <li>◦ Individual #12 - According to documentation reviewed the individual is required to have a plan. Plan in file was not current.</li> </ul> </li> <li>• Day Program/Day Supports Attendance <ul style="list-style-type: none"> <li>◦ Individual #12 - According to documentation reviewed the individual is required to have a plan. Plan in file was not current.</li> </ul> </li> <li>• <b>Crisis Plans/Medical Emergency Response Plans</b> <ul style="list-style-type: none"> <li>• Allergies-Phenobarbital <ul style="list-style-type: none"> <li>◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> <li>• Seizures <ul style="list-style-type: none"> <li>◦ Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> </ul> </li> </ul>		
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<p>professional.</p> <p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(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.</p> <p>(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.</p> <p>(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):</p> <p>(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.</p> <p>(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.</p> <p>(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</p>			
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shall be specified in the plan.

(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.

(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.

(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.

(g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author.

(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.

**(4) General Nursing Documentation**

(a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.

(b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.

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

**CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS**

**B. IDT Coordination**

(1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and

(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.

**Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010**

F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:

1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual ...

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> 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.</p> <p><b>C. Orientation and Training Requirements:</b> Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(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</p> <p>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p> <p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 10 of 13 Direct Service Professionals.</p> <p>Review of Direct Service Professionals training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> <li>• Pre- Service (DSP #41, 47 &amp; 49)</li> <li>• Foundation for Health &amp; Wellness (DSP #47)</li> <li>• Person-Centered Planning (1-Day) (DSP #44 &amp; 46)</li> <li>• First Aid (DSP #42, 44, 45, 46, 47, 50 &amp; 52)</li> <li>• CPR (DSP #42, 44, 45, 46, 48, 50 &amp; 52)</li> <li>• Assisting With Medication Delivery (DSP #52)</li> <li>• Rights &amp; Advocacy (DSP #42)</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p>

accordance with the specifications described in the individual service plan (ISP) of each individual served.

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

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

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

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

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

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

I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services.

Tag # 1A22 Staff Competence	Scope and Severity Rating: D	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> 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.</p> <p><b>F. Qualifications for Direct Service Personnel:</b> The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</p> <ol style="list-style-type: none"> <li>(1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times;</li> <li>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</li> <li>(3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual;</li> <li>(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy</li> </ol>	<p>Based on interview, the Agency failed to ensure that training competencies were met for 1 of 5 Direct Service Professionals.</p> <p><b>When DSP were asked if the individual had a Speech Therapy Plan and what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #50 stated, “She does have a plan but I’m not sure what it covers. The SLP just comes in and works one on one with the client.” According to documentation reviewed, the Individual requires a Speech Therapy Plan. (Individual #7)</li> </ul> <p><b>When DSP were asked if the individual had an Occupational Therapy Plan and what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #50 stated, “I don’t recall.” According to documentation reviewed, the Individual requires an Occupational Therapy Plan. (Individual #8)</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p>

<p>Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and</p> <p>(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.</p> <p>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:</p> <p>(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p> <p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p>			
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Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E	
<p><b>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:</b> Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. <b>Provider requirement to inquire of registry.</b> A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. <b>Prohibited employment.</b> A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. <b>Documentation of inquiry to registry.</b> The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. <b>Documentation for other staff.</b> With</p>	<p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 5 of 15 Agency Personnel.</p> <p><b>The following Agency personnel records contained no evidence of the Employee Abuse Registry being completed:</b></p> <ul style="list-style-type: none"> <li>• #43 – Date of hire 03/01/2011</li> </ul> <p><b>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</b></p> <ul style="list-style-type: none"> <li>• #40 – Date of hire 08/16/2007. Completed 02/11/2008.</li> <li>• #46 – Date of hire 03/01/2011. Completed 03/03/2011.</li> <li>• #47 – Date of hire 04/01/2010. Completed 04/08/2010.</li> <li>• #54 – Date of hire 03/01/2011. Completed 03/03/2011.</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p>



respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.

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

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

**Chapter 1.IV. General Provider Requirements.**

**D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: D	
<p><b>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</b></p> <p><b>A. Duty To Report:</b></p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(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:</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</p> <p>(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.</p> <p><b>B. Notification: (1) Incident Reporting:</b> 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, <a href="http://dhi.health.state.nm.us/elibrary/ironline/ir.php">http://dhi.health.state.nm.us/elibrary/ironline/ir.php</a> or may be obtained from the department by calling the toll free number.</p>	<p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 12 individuals.</p> <p>Individual #4</p> <ul style="list-style-type: none"> <li>• Incident date 08/12/2011. Allegation was Neglect &amp; Emergency Services. Incident report was received 08/19/2011. Failure to Report. IMB Late &amp; Failure Report indicated incident of Neglect was "Confirmed."</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

<p><b>Tag # 1A28.1 (CoP) Incident Mgt. System - Personnel Training</b></p>	<p><b>Scope &amp; Severity Rating: E</b></p>	
<p><b>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p><b>D. Training Documentation:</b> All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p> <p><b>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</b></p> <p><b>II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p>	<p>Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 8 of 15 Agency Personnel.</p> <p><b>Direct Service Professional Personnel (DSP):</b></p> <ul style="list-style-type: none"> <li>Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers' Property) (#40, 45, 47, 48, 50, 51 &amp; 52)</li> </ul> <p><b>When Direct Service Professionals were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect &amp; Misappropriation of Consumers' Property, the following was reported:</b></p> <ul style="list-style-type: none"> <li>DSP #46 stated, "I would fill out an internal report and give it to the service coordinator and they do the contacting. I can't remember the exact name of the state agency they report to."</li> <li>DSP #47 stated, "I don't know."</li> <li>DSP #51 stated, "The Department of Health." DSP failed to mention Adult Protective Services (APS).</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

<b>Tag # 1A28.2 (CoP) Incident Mgt. System - Parent/Guardian Training</b>	<b>Scope &amp; Severity Rating: F</b>	
<p><b>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p><b>E. Consumer and Guardian Orientation Packet:</b> Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.</p>	<p>Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 10 of 12 individuals.</p> <ul style="list-style-type: none"> <li>• Parent/Guardian Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers' Property) (#1, 3, 4, 5, 6, 7, 8, 9, 11 &amp; 12)</li> </ul>	<p>Provider: Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

Tag # 1A32 & 6L14 (CoP) ISP Implementation	Scope and Severity Rating: D	
<p><b>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP.</b> 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.</p> <p>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.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 2 of 12 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p><b>Administrative Files Reviewed:</b></p> <p><b>Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #6</p> <ul style="list-style-type: none"> <li>• None found for 03/2011 – 05/2011</li> </ul> <p>Individual #9</p> <ul style="list-style-type: none"> <li>• None found regarding: Individual #9 “will stay on task while taking full z-racks into the retail store” for 03/2011 &amp; 04/2011.</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p>

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> 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.</p> <p><b>C. Orientation and Training Requirements:</b> Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(2) <b>Individual-specific training</b> for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p> <p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 -</b></p> <p><b>II. POLICY STATEMENTS:</b></p> <p><b>A.</b> Individuals shall receive services from competent and qualified staff.</p> <p><b>B.</b> Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</p>	<p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 2 of 15 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <p><b>Direct Service Professional Personnel (DSP):</b></p> <ul style="list-style-type: none"> <li>• Individual Specific Training (#41 &amp; 49)</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>E. Provider Agency Reporting Requirements:</b> All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation:</p> <ol style="list-style-type: none"> <li>(1) Identification and implementation of a meaningful day definition for each person served;</li> <li>(2) Documentation summarizing the following: <ol style="list-style-type: none"> <li>(a) Daily choice-based options; and</li> <li>(b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP.</li> </ol> </li> <li>(3) Significant changes in the individual's routine or staffing;</li> <li>(4) Unusual or significant life events;</li> <li>(5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;</li> <li>(6) Record of personally meaningful community inclusion;</li> <li>(7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and</li> <li>(8) Any additional reporting required by DDSD.</li> </ol>	<p>Based on record review, the Agency failed to complete quarterly reports as required for 4 of 12 individuals receiving Community Inclusion services.</p> <p><b>Supported Employment Quarterly Reports</b></p> <ul style="list-style-type: none"> <li>• Individual #3 - None found for 04/2010 – 01/2011</li> <li>• Individual #7 - None found for 02/2011 – 04/2011</li> <li>• Individual #8 - None found for 12/2010 – 05/2011</li> <li>• Individual #12 - None found for 12/2010 – 02/2011</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>	

Tag # 5I22 SE Agency Case File	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</b></p> <p><b>D. Provider Agency Requirements</b></p> <p>(1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.</p> <p>(2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:</p> <p>(a) Quarterly progress reports;</p> <p>(b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD;</p> <p>(c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks</p>	<p>Based on record review and interview, the Agency failed to maintain a confidential case file for each individual for 8 of 12 individuals receiving Supported Employment Services.</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• Vocational Assessment (#1, 2, 3, 4, 8, 10, 11 &amp; 12)</li> </ul> <p>When #55 was asked if these individual's had an original Vocational Assessment the following was reported:</p> <ul style="list-style-type: none"> <li>• #55 stated, "No they don't. We'll have to get those done for them."</li> </ul>	<p><u>Provider:</u> Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>



including the individual, as well and a review and reporting mechanism for mutual accountability; and

(d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973.

New Mexico Department of Health (DOH)  
Developmental Disabilities Supports Division  
(DDSD) Policy

**Policy Title: Vocational Assessment Profile**

**Policy Eff July 16, 2008**

**I. PURPOSE**

The intent of the policy is to ensure that individuals are identified who could benefit from Vocational Assessment Profiles (VAPs) and are supported to access this support.

**II. POLICY STATEMENT**

Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures.

Tag # 5I25 SE Reimbursement	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> 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.</p> <p><b>B. Billable Units:</b> 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:</p> <ol style="list-style-type: none"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ol> <p><b>MAD-MR: 03-59 Eff 1/1/2004</b></p> <p><b>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b></p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</b></p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 5 of 12 individuals</p> <p>Individual #2 May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 146 units of Supported Employment from 05/01/2011 through 05/31/2011. Documentation received accounted for 136 units.</li> </ul> <p>Individual #5 March 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 45.50 units of Supported Employment from 03/01/2011 through 03/31/2011. Documentation received accounted for 41.50 units.</li> </ul> <p>April 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 30 units of Supported Employment from 04/01/2011 through 04/23/2011. Documentation received accounted for 27 units.</li> </ul> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 43 units of Supported Employment from 05/01/2011 through 05/31/2011. Documentation received accounted for 39 units.</li> </ul> <p>Individual #7 March 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 453 units of Supported Employment from 03/01/2011 through 03/31/2011. Documentation received accounted for 449 units.</li> </ul> <p>Individual #11 March 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 384 units of Supported</li> </ul>	<p>Provider: Please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p>

<p><b>E. Reimbursement</b></p> <p>(1) Billable Unit:</p> <p>(a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job.</p> <p>(b) The <b>billable unit for Individual Supported Employment</b> is one hour with a maximum of four hours a month. The Individual Supported Employment hourly rate is for face-to-face time which is supported by non face-to-face activities as specified in the ISP and the performance based contract as negotiated annually with the provider agency. Individual Supported Employment is a minimum of one unit per month. If an individual needs less than one hour of face-to-face service per month the IDT Members shall consider whether Supported Employment Services need to be continued. Examples of non face-to-face services include:</p> <ul style="list-style-type: none"> <li>(i) Researching potential employers via telephone, Internet, or visits;</li> <li>(ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents;</li> <li>(iii) Arranging appointments for job tours, interviews, and job trials;</li> <li>(iv) Documenting job search and acquisition progress;</li> <li>(v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual's progress, needs and satisfaction; and</li> <li>(vi) Meetings with individual surrounding job development or retention not at the employer's site.</li> </ul> <p>(c) Intensive Supported Employment services are intended for individuals who need one-to-one, face-to-face support for 32 or more hours per month. The billable unit is one hour.</p> <p>(d) Group Supported Employment is a fifteen-</p>	<p>Employment from 03/01/2011 through 03/31/2011. Documentation received accounted for 360 units.</p> <p>May 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 434 units of Supported Employment from 05/01/2011 through 05/31/2011. Documentation received accounted for 339 units.</li> </ul> <p>Individual #12</p> <p>March 2011</p> <ul style="list-style-type: none"> <li>• The Agency billed 296 units of Supported Employment from 03/01/2011 through 03/31/2011. Documentation received accounted for 267 units.</li> </ul>		
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<p>minute unit.</p> <p>(e) Self-employment is a fifteen minute unit.</p> <p>(4) Billable Activities include:</p> <p>(a) Activities conducted within the scope of services;</p> <p>(b) Job development and related activities for up to ninety (90) calendar days) that result in employment of the individual for at least thirty (30) calendar days; and</p> <p>(c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDSD Regional Office.</p>			
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Date: January 25, 2012  
To: Mary Best, Executive Director  
Provider: Goodwill Industries of New Mexico  
Address: 5000 San Mateo NE  
State/Zip: Albuquerque, New Mexico 87109

E-mail Address: [mbest@goodwillnm.org](mailto:mbest@goodwillnm.org)

Region: Metro & NW Region  
Routine Survey: July 12 – 18, 2011  
Verification Survey: January 17, 2012  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Inclusion (Supported Employment)  
Survey Type: Verification  
Team Leader: Marty Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Best;

The Division of Health Improvement/Quality Management Bureau has completed a verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the Routine Survey on *July 12- 18, 2011*. The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

***Partial Compliance with Conditions of Participation***

This determination is based on non-compliance with one or more CMS waiver assurances at the Condition of Participation level as well as Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction. These findings will be reviewed by the DOH – Internal Review Committee during an upcoming review meeting. The findings are attached. You will be contacted by the Department for further instructions regarding your plan of correction requirements.

Please call the Plan of Correction Coordinator at 505-222-8647, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

*Marti Madrid, LBSW*

Marti Madrid, LBSW  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date:	January 17, 2012
Present:	<b><u>Goodwill Industries of New Mexico</u></b> Bill Kesatie, Community Program Manager  <b><u>DOH/DHI/QMB</u></b> Marti Madrid, LBSW, Team Lead/Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor
Exit Conference Date:	January 17, 2012
Present:	<b><u>Goodwill Industries of New Mexico</u></b> Mary Best, President, CEO Valerie McGlasson, Director Workforce Development Dan Kenaley, Program Manager  <b><u>DOH/DHI/QMB</u></b> Marti Madrid, LBSW, Team Lead/Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 12 1 - <i>Jackson</i> Class Members 11 - Non- <i>Jackson</i> Class Members 12 - Supported Employment
Person Served Records Reviewed	Number: 12
Direct Service Professionals Record Review	Number: 15
Service Coordinator Record Review	Number: 2
Administrative Files Reviewed	<ul style="list-style-type: none"><li>• Billing Records</li><li>• Medical Records</li><li>• Incident Management Records</li><li>• Personnel Files</li><li>• Training Records</li></ul>

- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Evacuation Drills
- Quality Assurance / Improvement Plan

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