Dear Ms. Cates;

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

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

**Compliance with all Conditions of Participation.**

This determination is based on your agency's compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

---

**DIVISION OF HEALTH IMPROVEMENT**

5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108

(505) 222-8623 • FAX: (505) 222-8661 • [http://www.dhi.health.state.nm.us](http://www.dhi.health.state.nm.us)

QMB Report of Findings – Liferoots, Inc. – Metro Region – August 18 - 21, 2014

Survey Report #: Q.15.1.DDW.D0886.5.RTN.01.14.289
**Plan of Correction:**
The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency’s compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the receipt of this letter.

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

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

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

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

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

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

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

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

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

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

Sincerely,

*Erica Nilsen, BA*

Erica Nilsen, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

---

Survey Report #:
Q:15.1.DDW.D0886.5.RTN.01.14.289
Survey Process Employed:

Entrance Conference Date: August 18, 2014

Present:

**Liferoots, Inc.**
Kathleen Cates, CEO/President
Gwendolyn Kiwanuka, Director

**DOH/DHI/QMB**
Erica Nilsen, BA, Team Lead/Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Nicole Brown, MBA, Healthcare Surveyor
Corrina Strain, BSN, RN, Healthcare Surveyor

Exit Conference Date: August 21, 2014

Present:

**Liferoots, Inc.**
Kathleen Cates, CEO/President
Gwendolyn Kiwanuka, Director

**DOH/DHI/QMB**
Erica Nilsen, BA, Team Lead/Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Nicole Brown, MBA, Healthcare Surveyor
Corrina Strain, BSN, RN, Healthcare Surveyor

Administrative Locations Visited
Number: 2 (1111 E. Menaul Albuquerque, New Mexico & 1009 Golf Course, Suite 105 Rio Rancho, New Mexico)

Total Sample Size
Number: 25

- 2 - Jackson Class Members
- 23 - Non-Jackson Class Members
- 2 - Adult Habilitation
- 19 - Customized Community Supports
- 7 – Community Integrated Employment Services

Persons Served Records Reviewed
Number: 25

Persons Served Interviewed
Number: 17

Persons Served Observed
Number: 8 (6 individuals were unavailable during the on-site survey and 2 individuals were on vacation)

Direct Support Personnel Interviewed
Number: 13

Direct Support Personnel Records Reviewed
Number: 15

Service Coordinator Records Reviewed
Number: 7

Administrative Processes and Records Reviewed:

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

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

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

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

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

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

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

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

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

**Instructions for Completing Agency POC:**

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

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

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

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

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Anthony Fragua at 505-231-7436 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Anthony Fragua, POC Coordinator in any of the following ways:
   a. Electronically at Anthony.Fragua@state.nm.us (preferred method)
   b. Fax to 505-222-8661, or
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.

6. QMB will notify you when your POC has been “approved” or “denied.”
   a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
   b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
   c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
   d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
   e. Please note that all POC correspondence will be sent electronically unless otherwise requested.

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

**POC Document Submission Requirements**

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

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.

2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).

3. All submitted documents must be annotated; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.

4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.

5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.

6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC. for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
   - Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
   - Copies of “void and adjust” forms submitted to Xerox State Healthcare, LLC. to correct all unjustified units identified and submitted for payment during your internal audit.

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

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

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency’s operational policies and procedures, Quality Management system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified in the QMB Report of Findings. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Within the QMB Service Domains there are fundamental regulations, standards, or policies with which a provider must be in essential compliance in order to ensure the health and welfare of individuals served known as Conditions of Participation (CoPs).

The Determination of Compliance for each service type is based on a provider’s compliance with CoPs in three (3) Service Domains.

Case Management Services:
- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:
- Qualified Provider
- Plan of Care
- Health, Welfare and Safety

Conditions of Participation (CoPs)

A CoP is an identified fundamental regulation, standard, or policy with which a provider must be in compliance in order to ensure the health and welfare of individuals served. CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances. A provider must be in compliance with CoPs to participate as a waiver provider.

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP. (See the next section for a list of CoPs.) The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team’s analysis establishes that there is an identified
potential for significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

CoPs and Service Domains for Case Management Supports are as follows:

**Service Domain: Level of Care**

Condition of Participation:

1. **Level of Care**: The Case Manager shall complete all required elements of the Long Term Care Assessment Abstract (LTCAA) to ensure ongoing eligibility for waiver services.

**Service Domain: Plan of Care**

Condition of Participation:

2. **Individual Service Plan (ISP) Creation and Development**: Each individual shall have an ISP. The ISP shall be developed in accordance with DDSD regulations and standards and is updated at least annually or when warranted by changes in the individual’s needs.

Condition of Participation:

3. **ISP Monitoring and Evaluation**: The Case Manager shall ensure the health and welfare of the individual through monitoring the implementation of ISP desired outcomes.

CoPs and Service Domain for ALL Service Providers is as follows:

**Service Domain: Qualified Providers**

Condition of Participation:

4. **Qualified Providers**: Agencies shall ensure support staff has completed criminal background screening and all mandated trainings as required by the DDSD.

CoPs and Service Domains for Living Supports and Inclusion Supports are as follows:

**Service Domain: Plan of Care**

Condition of Participation:

5. **ISP Implementation**: Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

**Service Domain: Health, Welfare and Safety**

Condition of Participation:

6. **Individual Health, Safety and Welfare (Safety)**: Individuals have the right to live and work in a safe environment.

Condition of Participation:

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

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

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

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

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

Providers receiving a repeat determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.
Guidelines for the Provider
Informal Reconsideration of Finding (IRF) Process

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

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

The following limitations apply to the IRF process:

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

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

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

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

**Deficiencies**

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

<table>
<thead>
<tr>
<th>Tag # 1A08</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
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</thead>
</table>
Chapter 5 (CIES) 3. Agency Requirements  
H. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy. Additional documentation that is required to be maintained at the administrative office includes:  
1. Vocational Assessments that are of quality and contain content acceptable to DVR and DDSD;  
2. Career Development Plans as incorporated in the ISP; and  
3. Documentation of evidence that services provided under the DDW are not otherwise available under the Rehabilitation Act of 1973 (DVR).  
Chapter 6 (CCS) 3. Agency Requirements:  
G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative | Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 10 of 25 individuals.  
Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:  
- Occupational Therapy Plan (#21)  
- Annual Physical (#11, 16, 19, 22)  
- Dental Exam  
  - Individual #3 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.  
  - Individual #14 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.  
  - Individual #22 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. | Provider:  
State your Plan of Correction for the deficiencies cited in this tag here: →  
Provider:  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |  |
office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. Additional documentation that is required to be maintained at the administrative office includes:

1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD.

Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 13 (IMLS) 2. Service Requirements: C. Documents to be maintained in the agency administrative office, include: (This is not an all inclusive list refer to standard as it includes other items)

- Emergency contact information;
- Conducted annually. No evidence of exam was found.

  • **Vision Exam**
    - Individual #1 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
    - Individual #6 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
    - Individual #15 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
    - Individual #22 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.

  • **Auditory Exam**
    - Individual #6 - As indicated by collateral documentation reviewed, exam was completed on 5/16/2012. Follow-up was to be completed in 2 years. No evidence of follow-up found.
• Personal identification;
• ISP budget forms and budget prior authorization;
• ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan (PBS), Behavior Crisis Intervention Plan (BCIP), or other relevant behavioral plans, Medical Emergency Response Plan (MERP), Healthcare Plan, Comprehensive Aspiration Risk Management Plan (CARMP), and Written Direct Support Instructions (WDSI);
• Dated and signed evidence that the individual has been informed of agency grievance/complaint procedure at least annually, or upon admission for a short term stay;
• Copy of Guardianship or Power of Attorney documents as applicable;
• Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays;
• Written consent by relevant health decision maker and primary care practitioner for self-administration of medication or assistance with medication from DSP as applicable;
• Progress notes written by DSP and nurses;
• Signed secondary freedom of choice form;
• Transition Plan as applicable for change of provider in past twelve (12) months.

DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release:
Consumer Record Requirements eff. 11/1/2012
III. Requirement Amendments(s) or Clarifications:
A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain
records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.

H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.


CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:

1. Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;

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

3. Progress notes and other service delivery documentation;

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

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

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

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

(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:
   (a) Complete file for the past 12 months;
   (b) ISP and quarterly reports from the current and prior ISP year;
   (c) Intake information from original admission to services; and
   (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.

NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
<table>
<thead>
<tr>
<th>Tag # 1A08.1</th>
<th>Agency Case File - Progress Notes</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
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<tbody>
<tr>
<td>Tag # 1A08.1</td>
<td>Agency Case File - Progress Notes</td>
<td>Standard Level Deficiency</td>
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</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</td>
<td>Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 1 of 25 Individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>Chapter 5 (CIES) 3. Agency Requirements: 6. Reimbursement A. 1. …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record…</td>
<td>Review of the Agency individual case files revealed the following items were not found:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</table>
| Chapter 6 (CCS) 3. Agency Requirements: 4. Reimbursement A. Record Requirements 1. …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… | **Customized Community Services Notes/Daily Contact Logs**  
- Individual #16 - None found for 5/2, 7, 9, 14, 28, 30. | | |
| Chapter 7 (CIHS) 3. Agency Requirements: 4. Reimbursement A. 1.….Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… | **Adult Habilitation Progress Notes/Daily Contact Logs**  
- Individual #6 - None found for 5/1, 2, 6, 8, 9, 13, 14, 15, 16, 19, 20, 21, 22, 23, 27, 29 and 6/2, 3, 9, 16, 20, 24, 25, 26, 27, 30. | | |
| Chapter 11 (FL) 3. Agency Requirements: 4. Reimbursement A. 1….Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… | | | |
| Chapter 12 (SL) 3. Agency Requirements: 2. Reimbursement A. 1…. Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… | | | |
Chapter 13 (IMLS) 3. Agency Requirements: 4. Reimbursement A. 1. …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record…

Chapter 15 (ANS) 4. Reimbursement A. 1. …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record…


CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual’s case file shall include the following requirements:

1. (3) Progress notes and other service delivery documentation;
Tag # 1A32 and LS14 / 6L14
Individual Service Plan Implementation

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 3 of 25 individuals.</td>
</tr>
<tr>
<td>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
</tr>
</tbody>
</table>

**Administrative Files Reviewed:**

**Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**

**Individual #15**
- None found regarding: Work/Learn Outcome/Action Step: “Will answer questions given by instructor related to the book and other related materials (1 time per week)” for 5/2014 - 7/2014.

**Individual #16**
- None found regarding: Fun Outcome/Action Step: “Will attend classes of her choice (1 - 2 times per week)” for 5/2014.
- None found regarding: Fun Outcome/Action Step: “Will independently Google 20 events this ISP year (1 time per month)” for 5/2014.

**Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**

**Individual #6**
| 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] | • According to the Work/Learn Outcome; Action Step for “Will work on her ceramic pieces” is to be completed 3 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2014. |
### Standard of Care

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

### Deficiencies

<table>
<thead>
<tr>
<th>Tag # 1A11.1</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transportation Training</strong></td>
<td>Based on record review, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 10 of 15 Direct Support Personnel.</td>
</tr>
</tbody>
</table>

**No documented evidence was found of the following required training:**

- Transportation (DSP #200, 201, 202, 203, 204, 209, 210, 211, 213, 214)

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

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

- **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
program in passenger transportation assistance before assisting any resident. The passenger transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of equipment, familiarity with state regulations governing the transportation of persons with disabilities, and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed.

(2) Any employee or agent of a regulated facility or agency who drives a motor vehicle provided by the facility or agency for use in the transportation of clients must complete:

(a) A state approved training program in passenger assistance and

(b) A state approved training program in the operation of a motor vehicle to transport clients of a regulated facility or agency. The motor vehicle transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of motor vehicles, familiarity with state regulations governing the transportation of persons with disabilities, maintenance and safety record keeping, training on hazardous driving conditions and a method for determining successful completion of the course. The course requirements above are examples and may be modified as needed.

(c) A valid New Mexico drivers license for the type of vehicle being operated consistent with State of New Mexico requirements.

(3) Each regulated facility and agency shall establish and enforce written policies (including training) and procedures for employees who provide assistance to clients with boarding or alighting from motor vehicles.

(4) Each regulated facility and agency shall establish and enforce written policies (including...
training and procedures for employees who operate motor vehicles to transport clients.


CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy.

CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;

CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy

CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:
A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff (Policy T-003: for Training
Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:
A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
<table>
<thead>
<tr>
<th>Tag # 1A20</th>
<th>Direct Support Personnel Training</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy</strong> - <strong>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</strong> - <strong>II. POLICY STATEMENTS:</strong></td>
<td></td>
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</tr>
<tr>
<td>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 14 of 15 Direct Support Personnel.</td>
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<tr>
<td>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</td>
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<tr>
<td>• First Aid (DSP #204, 205, 208, 209, 210, 213)</td>
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<tr>
<td>• CPR (DSP #204, 205, 208, 209, 210, 213)</td>
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<td></td>
</tr>
<tr>
<td>• Assisting With Medication Delivery (DSP #200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 212, 213, 214)</td>
<td></td>
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</tr>
<tr>
<td><strong>Provider:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
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<td></td>
</tr>
</tbody>
</table>

**Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
employment and before working alone with an individual receiving service.


CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy.

CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;

CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy

CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:
A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training
Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:
A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
<table>
<thead>
<tr>
<th>Tag # 1A22</th>
<th>Agency Personnel Competency</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>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:</td>
<td>Based on interview, the Agency did not ensure training competencies were met for 2 of 13 Direct Support Personnel.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced.</td>
<td>When DSP were asked if they received training on the Individual’s Service Plan and what the plan covered, the following was reported:</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</td>
<td>• DSP #204 stated, “No I have not been trained. It’s been scheduled two times but hasn’t occurred.” (Individual #22)</td>
<td>]</td>
</tr>
<tr>
<td>CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.</td>
<td>When DSP were asked if the individual had a Positive Behavioral Crisis Plan and if so, what the plan covered, the following was reported:</td>
<td></td>
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<td>• DSP #204 stated, “I don’t think he has one.” According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #19)</td>
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<tr>
<td></td>
<td>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:</td>
<td></td>
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<tr>
<td></td>
<td>• DSP #204 stated, “No health care plans, just MERPS.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Seizures. (Individual #19)</td>
<td></td>
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<td></td>
<td>When DSP were asked if the Individual had a Comprehensive Aspiration Risk Management Plan, the following was reported:</td>
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</table>
status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training.

CHAPTER 11 (FL) 3. Agency Requirements

B. Living Supports - Family Living Services

Provider Agency Staffing Requirements: 3. Training:

A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and

- DSP 208 stated, “She has no CARMP.” According to the ISP, the individual has a CARMP. (Individual #7)
Documentation for DDSD Training Requirements.
B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc), information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

CHAPTER 12 (SL) 3. Agency Requirements
B. Living Supports- Supported Living
Services Provider Agency Staffing Requirements: 3. Training:
A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.
B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc), and information about the individual’s preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
### Tag # 1A25
#### Criminal Caregiver History Screening

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

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

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

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

1. In cases where the criminal history record lists an arrest for a crime that would constitute a disqualifying conviction and no final disposition is listed for the arrest, the department will attempt to notify the applicant, caregiver or hospital caregiver and request information from the applicant, caregiver or hospital caregiver within timelines set forth in the department's notice regarding the final disposition of the arrest. Information requested by the department may be evidence, for example, a certified copy of an acquittal, dismissal or conviction of a lesser included crime.

2. An applicant's, caregiver's or hospital caregiver's failure to respond within the required

### Standard Level Deficiency

Based on record review, the Agency did not maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 5 of 22 Agency Personnel.

The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:

**Direct Support Personnel (DSP):**
- #202 – Date of hire 2/13/2002.
- #209 – Date of hire 9/17/2012.

**Service Coordination Personnel (SC):**

### Provider

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

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


timelines regarding the final disposition of the arrest for a crime that would constitute a disqualifying conviction shall result in the applicant’s, caregiver’s or hospital caregiver’s temporary disqualification from employment as a caregiver or hospital caregiver pending written documentation submitted to the department evidencing the final disposition of the arrest. Information submitted to the department may be evidence, for example, of the certified copy of an acquittal, dismissal or conviction of a lesser included crime. In instances where the applicant, caregiver or hospital caregiver has failed to respond within the required timelines the department shall provide notice by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A., of Section 7.1.9.9. (3) The department will not make a final determination for an applicant, caregiver or hospital caregiver with a pending potentially disqualifying conviction for which no final disposition has been made. In instances of a pending potentially disqualifying conviction for which no final disposition has been made, the department shall notify the care provider, applicant, caregiver or hospital caregiver by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A, of Section 7.1.9.9.

B. Employment Pending Reconsideration Determination: At the discretion of the care provider, an applicant, caregiver or hospital caregiver whose nationwide criminal history record reflects a disqualifying conviction and who has requested administrative reconsideration may continue conditional supervised employment pending a determination on reconsideration.
NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:

A. homicide;

B. trafficking, or trafficking in controlled substances;

C. kidnapping, false imprisonment, aggravated assault or aggravated battery;

D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;

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

F. crimes involving child abuse or neglect;

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

H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.
<table>
<thead>
<tr>
<th>Tag # 1A36</th>
<th>Service Coordination Requirements</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>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:</strong></td>
<td>Based on record review, the Agency did not ensure that Orientation and Training requirements were met for 4 of 7 Service Coordinators.</td>
</tr>
<tr>
<td></td>
<td>K. In addition to the applicable requirements described in policy statements B – I (above), direct support staff, direct support supervisors, and internal service coordinators shall complete DDSD-approved core curriculum training. Attachments A and B to this policy identify the specific competency requirements for the following levels of core curriculum training:</td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td></td>
<td>1. Introductory Level – must be completed within thirty (30) days of assignment to his/her position with the agency.</td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td></td>
<td>2. Orientation – must be completed within ninety (90) days of assignment to his/her position with the agency.</td>
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</tr>
<tr>
<td></td>
<td>3. Level I – must be completed within one (1) year of assignment to his/her position with the agency.</td>
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<td>NMAC 7.26.5.7 “service coordinator”: the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency</td>
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<tr>
<td></td>
<td>NMAC 7.26.5.11 (b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the service coordinators shall assure the action plans and strategies are implemented consistent with the</td>
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</table>
provisions of the ISP, and shall report to the
case manager on ISP implementation and the
individual’s progress on action plans within their
agencies; for persons funded solely by state
general funds, the service coordinator shall
assume all the duties of the independent case
manager described within these regulations; if
there are two or more “key” community service
provider agencies with two or more service
coordinator staff, the IDT shall designate which
service coordinator shall assume the duties of
the case manager; the criteria to guide the IDTs
selection are set forth as follows:

(i) the designated service coordinator shall
have the skills necessary to carry out the
duties and responsibilities of the case
manager as defined in these regulations;
(ii) the designated service coordinator shall
have the time and interest to fulfill the
functions of the case manager as defined in
these regulations;
(iii) the designated service coordinator shall
be familiar with and understand community
service delivery and supports;
(iv) the designated service coordinator shall
know the individual or be willing to become
familiar and develop a relationship with the
individual being served;
<table>
<thead>
<tr>
<th>Tag # 1A37</th>
<th>Individual Specific Training</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy</strong> - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</td>
<td>Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 16 of 22 Agency Personnel.</td>
<td></td>
</tr>
<tr>
<td>A. Individuals shall receive services from competent and qualified staff.</td>
<td>Review of personnel records found no evidence of the following:</td>
<td></td>
</tr>
<tr>
<td>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) for each individual serviced.</td>
<td><strong>Direct Support Personnel (DSP):</strong></td>
<td></td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: <strong>1.</strong> All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. <strong>3.</strong> Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.</td>
<td>- Individual Specific Training (DSP #202, 203, 204, 205, 206, 207, 208, 209, 210, 213, 214)</td>
<td></td>
</tr>
<tr>
<td><strong>Service Coordination Personnel (SC):</strong></td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>- Individual Specific Training (SC #215, 217, 219, 220, 221)</td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</table>

QMB Report of Findings – Liferoots, Inc. – Metro Region – August 18 - 21, 2014

Survey Report #: Q.15.1.DDW.D0886.5.RTN.01.14.289

Page 37 of 93
status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training.

CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services

Provider Agency Staffing Requirements: 3. Training:

A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and
Documentation for DDSD Training Requirements.

B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc), information about the individual’s preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

CHAPTER 12 (SL) 3. Agency Requirements
B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:
A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.
B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc), and information about the individual’s preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
### Standard of Care

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

<table>
<thead>
<tr>
<th>Tag #</th>
<th>CQI System</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A03</td>
<td>STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS</td>
</tr>
<tr>
<td>d.</td>
<td>PROVIDER shall have a Quality Management and Improvement Plan in accordance with the current MF Waiver Standards and/or the DD Waiver Standards specified by the DEPARTMENT. The Quality Management and Improvement Plan for DD Waiver Providers must describe how the PROVIDER will determine that each waiver assurance and requirement is met. The applicable assurances and requirements are: (1) level of care determination; (2) service plan; (3) qualified providers; (4) health and welfare; (5) administrative authority; and, (6) financial accountability. For each waiver assurance, this description must include:</td>
</tr>
<tr>
<td>i.</td>
<td>Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance;</td>
</tr>
<tr>
<td>ii.</td>
<td>The entities or individuals responsible for conducting the discovery/monitoring processes;</td>
</tr>
<tr>
<td>iii.</td>
<td>The types of information used to measure performance; and,</td>
</tr>
<tr>
<td>iv.</td>
<td>The frequency with which performance is measured.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not implement their Continuous Quality Management System as required by standard.</td>
</tr>
<tr>
<td>Review of the Agency’s CQI Plan revealed the following:</td>
</tr>
<tr>
<td>Based on record review and interview, the Agency had not fully implemented their Continuous Quality Management System as required by standard.</td>
</tr>
<tr>
<td>• Review of the findings identified during the on-site survey (August 18 - 21, 2014) and as reflected in this report of findings, the Agency had multiple deficiencies noted which indicates the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.</td>
</tr>
</tbody>
</table>

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

| Provider: |
| Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: |
CHAPTER 5 (CIES) 3. Agency Requirements: J. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.

1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

a. Implementation of ISPs: extent to which services are delivered in accordance with ISPs and associated support plans with WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;
3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:

a. Analysis of General Events Reports data in Therap;

b. Compliance with Caregivers Criminal History Screening requirements;

c. Compliance with Employee Abuse Registry requirements;

d. Compliance with DDSD training requirements;

e. Patterns of reportable incidents;

f. Results of improvement actions taken in previous quarters;

g. Sufficiency of staff coverage;

h. Effectiveness and timeliness of implementation of ISPs, and associated support including trends in achievement of individual desired outcomes;

i. Results of General Events Reporting data analysis;

j. Action taken regarding individual grievances;

k. Presence and completeness of required documentation;

l. A description of how data collected as part of the agency’s QA/QI Plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QA/QI process; and

m. Significant program changes.

CHAPTER 6 (CCS) 3. Agency Requirements: I. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and
analysis, and routine meetings to analyze the results of QI activities.

1. Development of a QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. Implementing a QI Committee: The QA/QI committee shall convene at least quarterly and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting shall be documented. The QA/QI review should address at least the following:
   a. The extent to which services are delivered in accordance with ISPs, associated support plans and WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;
   b. Analysis of General Events Reports data;
   c. Compliance with Caregivers Criminal History Screening requirements;
   d. Compliance with Employee Abuse Registry requirements;
   e. Compliance with DDSD training requirements;
   f. Patterns of reportable incidents; and
   g. Results of improvement actions taken in previous quarters.
3. The Provider Agencies must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:

a. Sufficiency of staff coverage;

b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes;

c. Results of General Events Reporting data analysis;

d. Action taken regarding individual grievances;

e. Presence and completeness of required documentation;

f. A description of how data collected as part of the agency’s QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and

g. Significant program changes.

CHAPTER 7 (CIHS) 3. Agency Requirements: G. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.

1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the
source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. Implementing a QA/QI Committee: The QA/QI committee shall convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

a. Implementation of ISPs: The extent to which services are delivered in accordance with ISPs and associated support plans and/or WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;

b. Analysis of General Events Reports data;

c. Compliance with Caregivers Criminal History Screening requirements;

d. Compliance with Employee Abuse Registry requirements;

e. Compliance with DDSD training requirements;

f. Patterns of reportable incidents; and

g. Results of improvement actions taken in previous quarters.

3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise request by DOH. The report must be kept on file at the agency, made available
for review by DOH and, upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:

a. Sufficiency of staff coverage;

b. Effectiveness and timeliness of implementation of ISPs and associated support plans and/or WDSI, including trends in achievement of individual desired outcomes;

c. Results of General Events Reporting data analysis;

d. Action taken regarding individual grievances;

e. Presence and completeness of required documentation;

f. A description of how data collected as part of the agency’s QA/QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and

g. Significant program changes.

CHAPTER 11 (FL) 3. Agency Requirements: H. Quality Improvement/Quality Assurance (QA/QI) Program: Family Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.

1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan
describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. **Implementing a QA/QI Committee**: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:
   a. The extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;
   b. Analysis of General Events Reports data;
   c. Compliance with Caregivers Criminal History Screening requirements;
   d. Compliance with Employee Abuse Registry requirements;
   e. Compliance with DDSD training requirements;
   f. Patterns in reportable incidents; and
   g. Results of improvement actions taken in previous quarters.

3. The Provider Agency must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:
   a. Sufficiency of staff coverage;
|  | b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes;  
|  | c. Results of General Events Reporting data analysis, Trends in category II significant events;  
|  | d. Patterns in medication errors;  
|  | e. Action taken regarding individual grievances;  
|  | f. Presence and completeness of required documentation;  
|  | g. A description of how data collected as part of the agency’s QI plan was used;  
|  | h. What quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and  
|  | i. Significant program changes.  

**CHAPTER 12 (SL) 3. Agency Requirements: B. Quality Assurance/Quality Improvement (QA/QI) Program:** Supported Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.

**1. Development of a QA/QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and
methods to evaluate whether implementation of improvements are working.

| 2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:
|   a. Implementation of the ISP and the extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration, and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;
|   b. Analysis of General Events Reports data;
|   c. Compliance with Caregivers Criminal History Screening requirements;
|   d. Compliance with Employee Abuse Registry requirements;
|   e. Compliance with DDSD training requirements;
|   f. Patterns in reportable incidents; and
|   g. Results of improvement actions taken in previous quarters.

| 2. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH, and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:
|   a. Sufficiency of staff coverage;
|   b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes;
|   c. Results of General Events Reporting data analysis, Trends in Category II significant events;
|   d. Patterns in medication errors;
e. Action taken regarding individual grievances;
f. Presence and completeness of required documentation;
g. A description of how data collected as part of the agency’s QA/QI plan was used, what quality improvement initiatives were undertaken, and the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and

h. Significant program changes.

CHAPTER 13 (IMLS) 3. Service Requirements:
F. Quality Assurance/Quality Improvement (QA/QI) Program:
   Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities.

1. Development of a QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. Implementing a QA/QI Committee: The QA/QI committee shall convene on at least on a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality improvement. For Intensive Medical Living
providers, at least one nurse shall be a member of this committee. The QA meeting shall be documented. The QA review should address at least the following:

a. Implementation of the ISPs, including the extent to which services are delivered in accordance with the ISPs and associated support plans and/or WDSI including the type, scope, amount, duration, and frequency specified in the ISPs as well as effectiveness of such implementation as indicated by achievement of outcomes;
b. Trends in General Events as defined by DDSD;
c. Compliance with Caregivers Criminal History Screening Requirements;
d. Compliance with DDSD training requirements;
e. Trends in reportable incidents; and
f. Results of improvement actions taken in previous quarters.

3. The Provider Agency must complete a QA/QI report annually by February 15\textsuperscript{th} of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarizes:

a. Sufficiency of staff coverage;
b. Effectiveness and timeliness of implementation of ISPs and associated Support plans and/or WDSI including trends in achievement of individual desired outcomes;
c. Trends in reportable incidents;
d. Trends in medication errors;
e. Action taken regarding individual grievances;
f. Presence and completeness of required documentation;
g. How data collected as part of the agency’s QA/QI was used, what quality improvement initiatives were undertaken, and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
h. Significant program changes.

CHAPTER 14 (ANS) 3. Service Requirements:
N. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities.

1. Development of a QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. Implementing a QA/QI Committee: The QA/QI committee shall convene on at least on a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality improvement. For Intensive Medical Living providers, at least one nurse shall be a member of this committee. The QA meeting shall be documented. The QA review should address at least the following:
   a. Trends in General Events as defined by DDSD;
   b. Compliance with Caregivers Criminal History Screening Requirements;
   c. Compliance with DDSD training requirements;
   d. Trends in reportable incidents; and
e. Results of improvement actions taken in previous quarters.

3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarizes:
   a. Sufficiency of staff coverage;
   b. Trends in reportable incidents;
   c. Trends in medication errors;
   d. Action taken regarding individual grievances;
   e. Presence and completeness of required documentation;
   f. How data collected as part of the agency’s QA/QI was used, what quality improvement initiatives were undertaken, and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
   g. Significant program changes

NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:
F. Quality assurance/quality improvement program for community-based service providers:
The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division’s investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide
the following internal monitoring and facilitating quality improvement program:

(1) community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements;

(2) community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and

(3) community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.
<table>
<thead>
<tr>
<th>Tag # 1A05 General Provider Requirements</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT ARTICLE 14. STANDARDS FOR SERVICES AND LICENSING</td>
<td>Based on record review, the Agency did not develop, implement and/or update written policies and procedures that comply with all DDSD policies and procedures.</td>
</tr>
<tr>
<td>a. The PROVIDER agrees to provide services as set forth in the Scope of Service, in accordance with all applicable regulations and standards including the current DD Waiver Service Standards and MF Waiver Service Standards.</td>
<td>Review of Agency policies and procedures found the following: <strong>No evidence of the following policy and procedure:</strong></td>
</tr>
<tr>
<td>ARTICLE 39. POLICIES AND REGULATIONS</td>
<td>Policy and Procedure for on-call system, including nursing on-call.</td>
</tr>
<tr>
<td>Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD…</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td></td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>Tag # 1A09.1</td>
<td>Standard Level Deficiency</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------</td>
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</tbody>
</table>
| **Medication Delivery**  
PRN Medication Administration | Medication Administration Records (MAR) were reviewed for the months of July and August 2014 |
| **NMAC 16.19.11.8 MINIMUM STANDARDS:**  
A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:  
(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:  
(i) Name of resident;  
(ii) Date given;  
(iii) Drug product name;  
(iv) Dosage and form;  
(v) Strength of drug;  
(vi) Route of administration;  
(vii) How often medication is to be taken;  
(viii) Time taken and staff initials;  
(ix) Dates when the medication is discontinued or changed;  
(x) The name and initials of all staff administering medications. | Based on record review, 1 of 25 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: |
| **Model Custodial Procedure Manual**  
D. Administration of Drugs | Individual #10  
July 2014  
During on-site survey Medication Administration Records were requested for months of July and August 2014. As of 8/21/2014, Medication Administration Records for July had not been provided.  
During on-site survey Physician Orders were requested. As of 8/21/2014, Physician Orders had not been provided. | Provider:  
State your Plan of Correction for the deficiencies cited in this tag here: |
| | August 2014  
During on-site survey Medication Administration Records were requested for months of July and August 2014. As of 8/21/2014, Medication Administration Records for August had not been provided.  
During on-site survey Physician Orders were requested. As of 8/21/2014, Physician Orders had not been provided. | Provider:  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: |
the exact amount to be used in a 24 hour period.


F. PRN Medication

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

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

H. Agency Nurse Monitoring

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

Department of Health Developmental Disabilities Supports Division (DDSD) -
Procedure Title: Medication Assessment and Delivery
Procedure Eff Date: November 1, 2006
C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).
a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.

4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).


**CHAPTER 11 (FL) 1 SCOPE OF SERVICES**

**A. Living Supports- Family Living Services:**
The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT):

19. Assisting in medication delivery, and related monitoring, in accordance with the DDSD’s Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and

**I. Healthcare Requirements for Family Living.**

3. **B.** Adult Nursing Services for medication oversight are required for all surrogate Lining Supports- Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication.

6. **Support Living- Family Living Provider Agencies** must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment.
and Delivery Policy and Procedures, the New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations.

a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;
b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:

   i. The name of the individual, a transcription of the physician’s or licensed health care provider’s prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;
   ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;
   iii. Initials of the individual administering or assisting with the medication delivery;
   iv. Explanation of any medication error;
   v. Documentation of any allergic reaction or adverse medication effect; and
   vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

c. The Family Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and
d. Information from the prescribing pharmacy regarding medications must be kept in the
home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications.

e. Medication Oversight is optional if the individual resides with their biological family (by affinity or consanguinity). If Medication Oversight is not selected as an Ongoing Nursing Service, all elements of medication administration and oversight are the sole responsibility of the individual and their biological family. Therefore, a monthly medication administration record (MAR) is not required unless the family requests it and continually communicates all medication changes to the provider agency in a timely manner to insure accuracy of the MAR.

i. The family must communicate at least annually and as needed for significant change of condition with the agency nurse regarding the current medications and the individual's response to medications for purpose of accurately completing required nursing assessments.

ii. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not deliver medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a Certified Medication Aide (CMA). Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements.

iii. If the substitute care provider is a surrogate (not related by affinity or consanguinity)
Medication Oversight must be selected and provided.

CHAPTER 12 (SL) 2. Service Requirements L. Training and Requirements: 3. Medication Delivery: Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.

a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;

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

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

   ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;

   iii. Initials of the individual administering or assisting with the medication delivery;

   iv. Explanation of any medication error;
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>v.</td>
<td>Documentation of any allergic reaction or adverse medication effect; and</td>
</tr>
<tr>
<td>vi.</td>
<td>For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</td>
</tr>
<tr>
<td>c.</td>
<td>The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and</td>
</tr>
<tr>
<td>d.</td>
<td>Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs, and symptoms of adverse events and interactions with other medications.</td>
</tr>
</tbody>
</table>

**CHAPTER 13 (IMLS)**

2. Service Requirements. B. There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations.


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

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

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

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

(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;

(c) Initials of the individual administering or assisting with the medication;

(d) Explanation of any medication irregularity;

(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

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

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

(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;
<table>
<thead>
<tr>
<th>Tag # 1A15.2 and IS09 / 5I09</th>
<th>Healthcare Documentation</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</strong></td>
<td><strong>Chapter 5 (CIES) 3. Agency Requirements</strong></td>
<td>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 4 of 25 individuals</td>
</tr>
<tr>
<td><strong>H. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy.</strong></td>
<td><strong>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 6 (CCS) 2. Service Requirements. E.</strong></td>
<td></td>
<td>• Medication Administration Assessment Tool (#9)</td>
</tr>
</tbody>
</table>
| **The agency nurse(s) for Customized Community Supports providers must provide the following services:** | | • Comprehensive Aspiration Risk Management Plan:  
  ➢ Incomplete (#7) |
| **1. Implementation of pertinent PCP orders; ongoing oversight and monitoring of the individual’s health status and medically related supports when receiving this service:** | | • Aspiration Risk Screening Tool (#9) |
| **3. Agency Requirements: Consumer Records Policy:** | **Semi-Annual Nursing Review of HCP/Medical Emergency Response Plans:** |  |
| **All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.** | |  
  • None found for 10/2013 - 3/2014 (#9)  
  • None found for 9/2013 - 2/2014 (#14)  
  • None found for 10/2013 - 3/2014 (#17)  
  |  |
| **Chapter 7 (CIHS) 3. Agency Requirements:** | **Medical Emergency Response Plans** |  |
| **E. Consumer Records Policy:** | • Aspiration  
  • Individual #7 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found.** |  |
CHAT, the Aspiration Risk Screening Tool (ARST), and the Medication Administration Assessment Tool (MAAT) and any other assessments deemed appropriate on at least an annual basis for each individual served, upon significant change of clinical condition and upon return from any hospitalizations. In addition, the MAAT must be updated for any significant change of medication regime, change of route that requires delivery by licensed or certified staff, or when an individual has completed training designed to improve their skills to support self-administration.

a. For newly-allocated or admitted individuals, assessments are required to be completed within three (3) business days of admission or two (2) weeks following the initial ISP meeting, whichever comes first.

b. For individuals already in services, the required assessments are to be completed no more than forty-five (45) calendar days and at least fourteen (14) calendar days prior to the annual ISP meeting.

c. Assessments must be updated within three (3) business days following any significant change of clinical condition and within three (3) business days following return from hospitalization.

d. Other nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken);
assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

e. Develop any urgently needed interim Healthcare Plans or MERPs per DDSD policy pending authorization of ongoing Adult Nursing services as indicated by health status and individual/guardian choice.

Chapter 12 (SL) 3. Agency Requirements:

D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

2. Service Requirements. L. Training and Requirements. 5. Health Related Documentation: For each individual receiving Living Supports- Supported Living, the provider agency must ensure and document the following:

| a. | That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has a MERP developed by a licensed nurse or other appropriate professional according to the DDSD Medical Emergency Response Plan Policy, that DSP have been trained to implement such plan(s), and ensure that a copy of such plan(s) are readily available to DSP in the home; |
| b. | That an average of five (5) hours of documented nutritional counseling is available annually, if recommended by the IDT and clinically indicated; |
| c. | That the nurse has completed 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 must be documented whether they occur by phone or in person; and

d. Document for each individual that:

i. The individual has a Primary Care Provider (PCP);

ii. The individual receives an annual physical examination and other examinations as specified by a PCP;

iii. The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;

iv. The individual receives a hearing test as specified by a licensed audiologist;

v. The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and

vi. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine).

vii. The agency nurse will provide the individual’s team with a semi-annual nursing report that discusses the services provided and the status of the individual in the last six (6) months. This may be provided electronically or in paper format to the team no later than (2) weeks prior to the ISP and semi-annually.

f. The Supported Living Provider Agency must ensure that activities conducted by agency nurses comply with the roles and responsibilities identified in these standards.

Chapter 13 (IMLS) 2. Service Requirements:
C. Documents to be maintained in the agency administrative office, include:
A. All assessments completed by the agency nurse, including the Intensive Medical Living Eligibility Parameters tool; for e-CHAT a printed copy of the current e-CHAT summary report shall suffice;

F. Annual physical exams and annual dental exams (not applicable for short term stays);

G. Tri-annual vision exam (Not applicable for short term stays. See Medicaid policy 8.310.6 for allowable exceptions for more frequent vision exam);

H. Audiology/hearing exam as applicable (Not applicable for short term stays; See Medicaid policy 8.324.6 for applicable requirements);

I. All other evaluations called for in the ISP for which the Services provider is responsible to arrange;

J. Medical screening, tests and lab results (for short term stays, only those which occur during the period of the stay);

L. Record of medical and dental appointments, including any treatment provided (for short term stays, only those appointments that occur during the stay);

O. Semi-annual ISP progress reports and MERP reviews (not applicable for short term stays);

P. Quarterly nursing summary reports (not applicable for short term stays);

NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible
recipient who is currently receiving or who has received services in the past.

B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

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 least the following information:
1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.


CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case
File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual’s case file shall include the following requirements…1, 2, 3, 4, 5, 6, 7, 8.

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: Chapter 1. III. E. (1 - 4)
(1) Documentation of nursing assessment
activities (2) Health related plans and (4)
General Nursing Documentation

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

CHAPTER 5 IV. COMMUNITY INCLUSION
SERVICES PROVIDER AGENCY
REQUIREMENTS B. IDT Coordination
(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.
<table>
<thead>
<tr>
<th>Tag # 1A27</th>
<th>Incident Mgt. Late and Failure to Report</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Duty to report:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers.</td>
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</tr>
<tr>
<td>(2) All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety.</td>
<td></td>
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</tr>
<tr>
<td>B. Reporter requirement. All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division’s hotline to report the incident.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Abuse, neglect, and exploitation, suspicious injury or death reporting: Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division’s toll-free hotline number 1-800-445-6242. Any consumer,</td>
<td></td>
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</tbody>
</table>

| Based on the Incident Management Bureau’s Late and Failure Reports, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 3 of 27 individuals. |

| Individual #16 |
| Incident date 12/18/2013. Allegation was Abuse. Incident report was received on 1/8/2014. IMB issued a Late Reporting for Abuse. |

| Individual #28 |
| Incident date 8/14/2013. Allegation was Neglect. Incident report was received on 8/15/2013. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Unsubstantiated.” |

| Individual #29 |
| Incident date 3/20/2014. Allegation was Neglect/Exploitation. Incident report was received on 3/21/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect/Exploitation was “Unconfirmed” |

| Provider: State your Plan of Correction for the deficiencies cited in this tag here: → |
| Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
family member, or legal guardian may call the division’s hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division’s abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division’s toll free hotline number, 1-800-445-6242.

(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers: In addition to calling the division’s hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division’s abuse, neglect, and exploitation or report of death form consistent with the requirements of the division’s abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division’s abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division’s website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct
knowledge of the incident participates in the preparation of the report form.

(3) **Limited provider investigation:** No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation.

(4) **Immediate action and safety planning:**
Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall:

(a) develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable;
(b) be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division’s direction, if necessary; and
(c) provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division’s website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057.

(5) **Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident.

(6) **Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the
consumer’s legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division’s investigative representative.

(7) **Case manager or consultant notification by community-based service providers:** The responsible community-based service provider shall notify the consumer’s case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant.

(8) **Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation.
<table>
<thead>
<tr>
<th>Tag # 5144</th>
<th>Adult Habilitation Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver</td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 1 of 2 individuals.</td>
</tr>
<tr>
<td>Service Standards effective 4/1/2007</td>
<td>Individual #6</td>
</tr>
<tr>
<td>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</td>
<td>May 2014</td>
</tr>
</tbody>
</table>
| A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. | • The Agency billed 29 units of Adult Habilitation (T2021 U1) from 5/1/2014 through 5/2/2014. Documentation did not contain the required elements on 5/1, 2. Documentation received accounted for 0 units. One or more of the following elements was not met:  
  ➢ No documentation found. |
| B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: | • The Agency billed 120 units of Adult Habilitation (T2021 U1) from 5/5/2014 through 5/9/2014. Documentation did not contain the required elements on 5/6, 8, 9. Documentation received accounted for 48 units. One or more of the following elements was not met:  
  ➢ No documentation found. |
| (1) Date, start and end time of each service encounter or other billable service interval; | • The Agency billed 120 units of Adult Habilitation (T2021 U1) from 5/12/2014 through 5/16/2014. Documentation did not contain the required elements on 5/13, 14, 15, 16. Documentation received accounted for 24 units. One or more of the following elements was not met:  
  ➢ No documentation found. |
| (2) A description of what occurred during the encounter or service interval; and | |
| (3) The signature or authenticated name of staff providing the service. | |
| MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: | |
| Providers must maintain all records necessary to fully disclose the extent of the services | |
| | |
| | Provider: State your Plan of Correction for the deficiencies cited in this tag here: → |
| | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.


## CHAPTER 5 XVI. REIMBURSEMENT

### A. Billable Unit

A billable unit for Adult Habilitation Services is in 15-minute increments. The rate is based on the individual’s level of care.

### B. Billable Activities

1. The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non-face-to-face under the following conditions: (a) Time that is non-face-to-face is documented separately and clearly identified as to the nature of the activity; and (b) Non face-to-face hours do not exceed 5% of the monthly billable hours.

2. Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours.

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity Description</th>
<th>Units Billed</th>
<th>Documentation Issues</th>
<th>Required Elements Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/19/2014</td>
<td>The Agency billed 116 units of Adult Habilitation (T2021 U1)</td>
<td>116</td>
<td>Documentation did not contain the required elements on 5/19, 20, 21, 22, 23. Documentation received accounted for 0 units.</td>
<td>No documentation found.</td>
</tr>
<tr>
<td>5/27/2014</td>
<td>The Agency billed 99 units of Adult Habilitation (T2021 U1)</td>
<td>99</td>
<td>Documentation did not contain the required elements on 5/27, 29. Documentation received accounted for 52 units.</td>
<td>No documentation found.</td>
</tr>
<tr>
<td>6/2/2014</td>
<td>The Agency billed 115 units of Adult Habilitation (T2021 U1)</td>
<td>115</td>
<td>Documentation did not contain the required elements on 6/2, 3. Documentation received accounted for 76 units.</td>
<td>No documentation found.</td>
</tr>
<tr>
<td>6/9/2014</td>
<td>The Agency billed 118 units of Adult Habilitation (T2021 U1)</td>
<td>118</td>
<td>Documentation did not contain the required elements on 6/9. Documentation received accounted for 36 units.</td>
<td>No documentation found.</td>
</tr>
<tr>
<td>6/16/2014</td>
<td>The Agency billed 67 units of Adult Habilitation (T2021 U1)</td>
<td>67</td>
<td>Documentation did not contain the required elements on 6/10. Documentation received accounted for 5 units.</td>
<td>No documentation found.</td>
</tr>
</tbody>
</table>

QMB Report of Findings – Liferoots, Inc. – Metro Region – August 18 - 21, 2014

Survey Report #: Q.15.1.DDW.D0886.5.RTN.01.14.289

Page 79 of 93
through 6/18/2014. Documentation did not contain the required elements on 6/16. Documentation received accounted for 54 units. One or more of the following elements was not met:
  ➢ No documentation found.

- The Agency billed 24 units of Adult Habilitation (T2021 U1) on 6/20/2014. Documentation did not contain the required elements on 6/20. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ No documentation found.

- The Agency billed 119 units of Adult Habilitation (T2021 U1) from 6/23/2014 through 6/27/2014. Documentation did not contain the required elements on 6/24, 25, 26, 27. Documentation received accounted for 24 units. One or more of the following elements was not met:
  ➢ No documentation found.

- The Agency billed 24 units of Adult Habilitation (T2021 U1) on 6/30/2014. Documentation did not contain the required elements on 6/30. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ No documentation found.
<table>
<thead>
<tr>
<th>Tag # IS30</th>
<th>Customized Community Supports Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Level Deficiency</strong></td>
<td></td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 6 (CCS) 4. REIMBURSEMENT A. Required Records: All Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, nature of services, and length of a session of service billed.</td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 13 of 18 individuals.</td>
</tr>
<tr>
<td>Individual #1 May 2014</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>• The Agency billed 17 units of Customized Community Supports (group) (T2021 HB U7) on 5/1/2014. Documentation received accounted for 14 units.</td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>• The Agency billed 43 units of Customized Community Supports (group) (T2021 HB U7) from 5/12/2014 through 5/14/2014. Documentation received accounted for 39 units.</td>
<td></td>
</tr>
<tr>
<td>June 2014</td>
<td></td>
</tr>
<tr>
<td>• The Agency billed 34 units of Customized Community Supports (group) (T2021 HB U7) on 6/3/2014. Documentation received accounted for 14 units.</td>
<td></td>
</tr>
<tr>
<td>Individual #2 May 2014</td>
<td></td>
</tr>
<tr>
<td>• The Agency billed 108 units of Customized Community Supports (group) (T2021 HB U7) from 5/12/2014 through 5/16/2014. Documentation did not contain the required elements on 5/12, 13, 14, 15, 16. Documentation received accounted for 0 units. One or more of the following elements was not met:</td>
<td></td>
</tr>
<tr>
<td>✓ Start time and end time of each service encounter or other billable service interval</td>
<td></td>
</tr>
<tr>
<td>1. 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 Human Services Department (HSD). For each unit billed, the record shall contain the following:</td>
<td></td>
</tr>
<tr>
<td>a. Date, start and end time of each service encounter or other billable service interval;</td>
<td></td>
</tr>
<tr>
<td>b. A description of what occurred during the encounter or service interval; and</td>
<td></td>
</tr>
<tr>
<td>c. The signature or authenticated name of staff providing the service.</td>
<td></td>
</tr>
<tr>
<td>B. Billable Unit: 1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit.</td>
<td></td>
</tr>
<tr>
<td>2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit.</td>
<td></td>
</tr>
</tbody>
</table>
3. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group.

4. The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Customized Community Supports without prior approval from DDSD.

5. The billable unit for Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit. (There is a separate rate established for individuals who require one-to-one (1:1) support either in the community or in a group day setting due to behavioral challenges (NM DDW group G).

6. The billable unit for Fiscal Management for Adult Education is dollars charged for each class including a 10% administrative processing fee.

C. Billable Activities:
1. All DSP activities that are:
   a. Provided face to face with the individual;
   b. Described in the individual’s approved ISP;
   c. Provided in accordance with the Scope of Services; and
   d. Activities included in billable services, activities or situations.
2. Purchase of tuition, fees, and/or related materials associated with adult education.

   • The Agency billed 113 units of Customized Community Supports (group) (T2021 HB U7) from 5/19/2014 through 5/23/2014. Documentation did not contain the required elements on 5/19, 20, 21, 22, 23. Documentation received accounted for 0 units. One or more of the following elements was not met:
     ➢ Start time and end time of each service encounter or other billable service interval

   • The Agency billed 78 units of Customized Community Supports (group) (T2021 HB U7) from 5/27/2014 through 5/30/2014. Documentation did not contain the required elements on 5/27, 28, 29, 30. Documentation received accounted for 0 units. One or more of the following elements was not met:
     ➢ Start time and end time of each service encounter or other billable service interval

   Individual #8
   May 2014
   • The Agency billed 42 units of Customized Community Supports (group) (T2021 HB U7) on 5/1/2014. Documentation received accounted for 21 units.

   • The Agency billed 64 units of Customized Community Supports (group) (T2021 HB U7) from 5/13/2014 through 5/15/2014. Documentation did not contain the required elements on 5/13, 14, 15. Documentation received accounted for 0 units. One or more of the following elements was not met:
opportunities as related to the ISP Action Plan and Outcomes, not to exceed $550 including administrative processing fee.

3. Customized Community Supports can be included in ISP and budget with any other services.

MAD-MR: 03-59 Eff 1/1/2004
8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:
Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.

- Start time and end time of each service encounter or other billable service interval.
- The Agency billed 63 units of Customized Community Supports (group) (T2021 HB U7) from 5/20/2014 through 5/22/2014. Documentation did not contain the required elements on 5/20, 21, 22. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Start time and end time of each service encounter or other billable service interval.
- The Agency billed 21 units of Customized Community Supports (group) (T2021 HB U7) on 5/27/2014. Documentation did not contain the required elements on 5/27. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Start time and end time of service encounter or other billable service interval
- The Agency billed 21 units of Customized Community Supports (group) (T2021 HB U7) on 5/29/2014. Documentation received accounted for 10 units.
- The Agency billed 63 units of Customized Community Supports (group) (T2021 HB U7) from 6/24/2014 through 6/25/2014. Documentation received accounted for 42 units.

June 2014
- The Agency billed 63 units of Customized Community Supports (group) (T2021 HB U7) from 6/24/2014 through 6/25/2014. Documentation received accounted for 42 units.

Individual #9
May 2014
<table>
<thead>
<tr>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- The Agency billed 23 units of Customized Community Supports (group) (T2021 HB U8) on 6/20/2014. Documentation received accounted for 21 units.</td>
</tr>
<tr>
<td>July 2014</td>
<td>- The Agency billed 16 units of Customized Community Supports (group) (T2021 HB U8) on 7/24/2014. Documentation did not contain the required elements on 7/24. Documentation received accounted for 0 units. One or more of the following elements was not met:</td>
</tr>
<tr>
<td></td>
<td>- Start time and end time of service encounter or other billable service interval</td>
</tr>
<tr>
<td></td>
<td>- Individual #10</td>
</tr>
<tr>
<td></td>
<td>- The Agency billed 57 units of Customized Community Supports (group) (T2021 HB U8) from 7/22/2014 through 7/24/2014. Documentation did not contain the required elements on 7/22, 23, 24. Documentation received accounted for 0 units. One or more of the following elements was not met:</td>
</tr>
<tr>
<td></td>
<td>- Start time and end time of each service encounter or other billable service interval</td>
</tr>
<tr>
<td></td>
<td>- Individual #11</td>
</tr>
<tr>
<td></td>
<td>- The Agency billed 30 units of Customized Community Supports (group) (T2021 HB U8) from 5/29/2014 through 5/30/2014. Documentation received accounted for 27 units.</td>
</tr>
<tr>
<td></td>
<td>- The Agency billed 23 units of Customized Community Supports (group) (T2021 HB U8) on 6/20/2014. Documentation received accounted for 21 units.</td>
</tr>
<tr>
<td></td>
<td>- The Agency billed 16 units of Customized Community Supports (group) (T2021 HB U8) on 7/24/2014. Documentation did not contain the required elements on 7/24. Documentation received accounted for 0 units. One or more of the following elements was not met:</td>
</tr>
<tr>
<td></td>
<td>- Start time and end time of service encounter or other billable service interval</td>
</tr>
</tbody>
</table>
The Agency billed 48 units of Customized Community Supports (group) (T2021 HB U7) from 6/9/2014 through 6/10/2014. Documentation did not contain the required elements on 6/9. Documentation received accounted for 25 units. One or more of the following elements was not met:
- End time of service encounter or other billable service interval

July 2014
- The Agency billed 68 units of Customized Community Supports (group) (T2021 HB U7) on 7/25/2014. Documentation received accounted for 24 units.
- The Agency billed 41 units of Customized Community Supports (group) (T2021 HB U7) on 7/29/2014. Documentation received accounted for 20 units.

Individual #13
May 2014
- The Agency billed 57 units of Customized Community Supports (group) (T2021 HB U7) from 5/5/2014 through 5/7/2014. Documentation received accounted for 53 units.

Individual #16
May 2014
- The Agency billed 19 units of Customized Community Supports (group) (T2021 HB U8) on 5/2/2014. Documentation did not contain the required elements on 5/2. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - No documentation found.
<table>
<thead>
<tr>
<th>Date</th>
<th>Units Billed</th>
<th>Documentation Status</th>
<th>Elements Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/7/2014</td>
<td>18</td>
<td>0 units</td>
<td>No documentation found</td>
</tr>
<tr>
<td>5/9/2014</td>
<td>18</td>
<td>0 units</td>
<td>No documentation found</td>
</tr>
<tr>
<td>5/14/2014</td>
<td>18</td>
<td>0 units</td>
<td>No documentation found</td>
</tr>
<tr>
<td>5/28/2014</td>
<td>20</td>
<td>0 units</td>
<td>No documentation found</td>
</tr>
<tr>
<td>5/30/2014</td>
<td>18</td>
<td>0 units</td>
<td>No documentation found</td>
</tr>
</tbody>
</table>

The Agency billed 18 units of Customized Community Supports (group) (T2021 HB U8) on 5/7/2014. Documentation did not contain the required elements on 5/7. Documentation received accounted for 0 units. One or more of the following elements was not met:
- No documentation found.

The Agency billed 18 units of Customized Community Supports (group) (T2021 HB U8) on 5/9/2014. Documentation did not contain the required elements on 5/9. Documentation received accounted for 0 units. One or more of the following elements was not met:
- No documentation found.

The Agency billed 18 units of Customized Community Supports (group) (T2021 HB U8) on 5/14/2014. Documentation did not contain the required elements on 5/14. Documentation received accounted for 0 units. One or more of the following elements was not met:
- No documentation found.

The Agency billed 20 units of Customized Community Supports (group) (T2021 HB U8) on 5/28/2014. Documentation did not contain the required elements on 5/28. Documentation received accounted for 0 units. One or more of the following elements was not met:
- No documentation found.

The Agency billed 18 units of Customized Community Supports (group) (T2021 HB U8) on 5/30/2014. Documentation did not contain the required elements on 5/30.
<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
</table>
| June 2014  | The Agency billed 20 units of Customized Community Supports (group) (T2021 HB U8) on 6/6/2014. Documentation did not contain the required elements on 6/6. Documentation received accounted for 0 units. One or more of the following elements was not met:  
  - Start time and end time of service encounter or other billable service interval |
|            | The Agency billed 15 units of Customized Community Supports (group) (T2021 HB U8) on 6/13/2014. Documentation did not contain the required elements on 6/13. Documentation received accounted for 0 units. One or more of the following elements was not met:  
  - Start time of service encounter or other billable service interval |
|            | The Agency billed 18 units of Customized Community Supports (group) (T2021 HB U8) on 6/27/2014. Documentation did not contain the required elements on 6/27. Documentation received accounted for 0 units. One or more of the following elements was not met:  
  - End time of each service encounter or other billable service interval |

Individual #18
May 2014
• The Agency billed 70 units of Customized Community Supports (group) (T2021 HB U7) from 5/6/2014 through 5/8/2014. Documentation did not contain the required elements on 5/7, 8. Documentation received accounted for 23 units. One or more of the following elements was not met:
  ➢ Start time and end time of each service encounter or other billable service interval

June 2014
• The Agency billed 54 units of Customized Community Supports (group) (T2021 HB U7) from 6/3/2014 through 6/5/2014. Documentation did not contain the required elements on 6/3, 4, 5. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ Start time and end time of each service encounter or other billable service interval

• The Agency billed 66 units of Customized Community Supports (group) (T2021 HB U7) from 6/10/2014 through 6/12/2014. Documentation did not contain the required elements on 6/10, 11, 12. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ Start time and end time of each service encounter or other billable service interval

Individual #20
July 2014
• The Agency billed 10 units of Customized Community Supports (group) (T2021 HB U7) on 7/30/2014. Documentation did not contain the required elements on 7/30.
Documentation received accounted for 0 units. One or more of the following elements was not met:

- Date, start and end time of each service encounter or other billable service interval

**Individual #23**
May 2014

- The Agency billed 108 units of Customized Community Supports (group) (T2021 HB U7) from 5/19/2014 through 5/23/2014. Documentation did not contain the required elements on 5/21. Documentation received accounted for 87 units. One or more of the following elements was not met:
  - Start time and end time of service encounter or other billable service interval

June 2014

- The Agency billed 21 units of Customized Community Supports (group) (T2021 HB U7) on 6/30/2014. Documentation did not contain the required elements on 6/30. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Start time and end time of service encounter or other billable service interval

**Individual #24**
May 2014

- The Agency billed 26 units of Customized Community Supports (group) (T2021 HB U7) on 5/5/2014. Documentation did not contain the required elements on 5/5. Documentation received accounted for 0 units. One or more of the following elements was not met:
- Start time and end time of service encounter or other billable service interval

- The Agency billed 26 units of Customized Community Supports (group) (T2021 HB U7) on 5/7/2014. Documentation did not contain the required elements on 5/7. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Start time and end time of service encounter or other billable service interval

- The Agency billed 10 units of Customized Community Supports (group) (T2021 HB U7) on 5/14/2014. Documentation did not contain the required elements on 5/14. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Start time and end time of service encounter or other billable service interval

- The Agency billed 49 units of Customized Community Supports (group) (T2021 HB U7) from 5/19/2014 through 5/20/2014. Documentation did not contain the required elements on 5/19, 20. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Start time and end time of each service encounter or other billable service interval

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
</table>
| 5/22, 23   | Documentation did not contain the required elements. One or more of the following elements was not met:  
|            | - Start time and end time of each service encounter or other billable service interval |
|            | - The Agency billed 72 units of Customized Community Supports (group) (T2021 HB U7) on 5/28/2014. Documentation did not contain the required elements on 5/28. Documentation received accounted for 0 units. One or more of the following elements was not met:  
|            | - Start time and end time of service encounter or other billable service interval |
| Individual # 27 May 2014 | The Agency billed 41 units of Customized Community Supports (group) (T2021 HB U8) from 5/8/2014 through 5/9/2014. Documentation did not contain the required elements on 5/9. Documentation received accounted for 21 units. One or more of the following elements was not met:  
|            | - End time of each service encounter or other billable service interval |
Date: January 23, 2015

To: Kathleen Cates, CEO/President
Provider: Liferoots, Inc.
Address: 1111 Menaul Blvd. NE
State/Zip: Albuquerque, New Mexico 87107

E-mail Address: kathleenc@liferootsnm.org
CC: Gwendolyn Kiwanuka, Director
E-Mail Address gwendolynk@liferootsnm.org

Region: Metro
Survey Date: August 18 - 21, 2014
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: 2012: Inclusion Supports (Customized Community Supports, Community Integrated Employment Services)
2007: Community Living (Community Inclusion (Adult Habilitation))
Survey Type: Routine

Dear Ms. Cates & Ms. Kiwanuka:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,
Tony Fragua