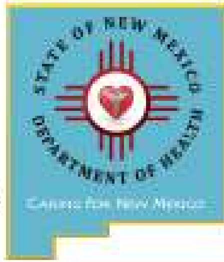


Date: January 25, 2012

To: Jon Hellebust, Executive Director

Provider: LLCP NMDOH
Address: 445 Camino Del Ray, Suite A
State/Zip: Los Lunas, New Mexico 87031

E-mail Address: jon.hellebust@state.nm.us
Cc E-mail Address: angie.brooks@state.nm.us

Region: Metro
Routine Survey: April 11 – 15, 2011
Verification Survey: December 13 – 15, 2011
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation & Supported Employment)
Survey Type: Verification
Team Leader: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; William Bazinet, BSN, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Cynthia Nielsen, MSN, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Hellebust;

The Division of Health Improvement/Quality Management Bureau has completed a verification survey of the services identified above. The purpose of the survey was to determine compliance with you Plan of Correction submitted to DHI regarding the Routine Survey on April 11 – 15, 2011. The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

Partial Compliance with Conditions of Participation

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

Please call the Plan of Correction Coordinator at 505-222-8647, if you have questions about the survey or the report.

Thank you for your cooperation and for the work you perform.

Sincerely,

Tony Fragua, BFA

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

Survey Process Employed:

Entrance Conference Date:	December 13, 2011	
Present:	**LLCP NMDOH** Angie Brooks, Program Manager Jill Marshall, Service Coordinator Manager **DOH/DHI/QMB** Tony Fragua, BFA, Team Lead/Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor William Bazinet, BSN, RN, Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor Cynthia Nielsen, MSN, RN, Healthcare Surveyor Scott Good, MRC, CRC, Deputy Bureau Chief	
Exit Conference Date:	December 15, 2011	
Present:	**LLCP NMDOH** Jon Hellebust, Executive Director Angie Brooks, Program Manager Paula Jean Walker, Administration Support David McMullough, RN Rosalie Leyba, Residential Coordinator Andrew Smith, Residential Coordinator Annette Baca, Residential Coordinator Leslie Churan, RN Emily Griffey, RN, Director of Nursing Cindy Bascom, LPN Jill Marshall, Service Coordinator Manager Bernalina Soto, RN Sandra Valdez, RN **DOH/DHI/QMB** Tony Fragua, BFA, Team Lead/Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor William Bazinet, BSN, RN, Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor Cynthia Nielsen, MSN, RN, Healthcare Surveyor Jennifer Bruns, BSW, Healthcare Surveyor	
Total Homes Visited	Number:	12
❖ Supported Homes Visited	Number:	7
❖ Family Homes Visited	Number:	5
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	17 6 - *Jackson* Class Members 11 - Non-*Jackson* Class Members 11 - Supported Living 6 - Family Living 12 - Adult Habilitation 4 - Supported Employment
Direct Service Professionals Record Review	Number:	217
Service Coordinator Record Review	Number:	8
Service Coordinator Professionals Interviewed	Number:	1

Records Reviewed (Persons Served) Number: 17

Administrative Files Reviewed

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

QMB Scope and Severity Matrix

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

<table>
<tr><td colspan="3"></td><td colspan="3">**SCOPE**</td></tr>
<tr><td rowspan="6">**SEVERITY**</td><td colspan="2"></td><td>**Isolated 01% - 15%**</td><td>**Pattern 16% - 79%**</td><td>**Widespread 80% - 100%**</td></tr>
<tr><td rowspan="2">**High Impact**</td><td>Immediate Jeopardy to individual health and or safety</td><td>**J.**</td><td>**K.**</td><td>**L.**</td></tr>
<tr><td>Actual harm</td><td>**G.**</td><td>**H.**</td><td>**I.**</td></tr>
<tr><td rowspan="2">**Medium Impact**</td><td rowspan="2">No Actual Harm
Potential for more than minimal harm</td><td>**D.**</td><td rowspan="2">**E.**</td><td>**F.** (3 or more)</td></tr>
<tr><td>**D.** (2 or less)</td><td>**F.** (no conditions of participation)</td></tr>
<tr><td>**Low Impact**</td><td>No Actual Harm
Minimal potential for harm.</td><td>**A.**</td><td>**B.**</td><td>**C.**</td></tr>
</table>

Scope and Severity Definitions:

- Isolated:

A deficiency that is limited to 1% to 15% of the sample, usually impacting few individuals in the sample.

- Pattern:

A deficiency that impacts a number or group of individuals from 16% to 79% of the sample is defined as a pattern finding. Pattern findings suggest the need for system wide corrective actions.

- Widespread:

A deficiency that impacts most or all (80% to 100%) of the individuals in the sample is defined as widespread or pervasive. Widespread findings suggest the need for system wide corrective actions as well as the need to implement a Continuous Quality Improvement process to improve or build infrastructure. Widespread findings could be referred to the Internal Review Committee for review and possible actions or sanctions.

Attachment C

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

Introduction:
Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means that surveyors have clarified issues and/or requested missing information before completing the review. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

Instructions:

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

2. The written request for an IRF must be completed on the QMB Request for Informal Reconsideration of Finding Form available on the QMB website: http://dhi.health.state.nm.us/qmb

3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.

4. The IRF request must include all supporting documentation or evidence.

The following limitations apply to the IRF process:

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

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

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

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

Agency: **LLCP NMDOH - Metro Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation & Supported Employment)
Monitoring Type: Verification Survey
Routine Survey: **April 11 – 15, 2011**
Verification Survey: **December 13 – 15, 2011**

Standard of Care	April 11 – 15, 2011 Deficiencies	December 13 – 15, 2011 Verification Survey – New and Repeat Deficiencies
Tag # 1A09.1 Medication Delivery - PRN Medication	**Scope and Severity Rating: E**	**Scope and Severity Rating: D**
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **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	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 8 of 21 Individuals. Individual #1 December 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Hydrocodone- APAP 5-500 – PRN – 12/30 (given1 time) January 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN) February 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN)	**New & Repeat Findings:** Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 2 of 17 Individuals. Individual #8 November 2011 Medication Administration Records did not contain the circumstance for which the medication is to be used: • Hydrocodone APAP 7.5/500 give 5-10 cc (PRN) Individual #19 November 2011 Medication Administration Records did not contain the Initials of the individual administering or assisting with the medication for the following medications: • Lac-Hydrin 12% Cream (apply 2 times daily) – PRN – 11/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 • Mupriocin 2% Ointment (apply 3 times daily) –

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 administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered	Individual #6 December 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Bisacodyl EC 5mg (PRN) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN) January 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Bisacodyl EC 5mg (PRN) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN) February 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Bisacodyl EC 5mg (PRN) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN) Individual #7 December 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN) January 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN) February 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:	PRN – 11/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Lac-Hydrin 12% Cream (apply 2 times daily) – PRN – 11/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 • Mupriocin 2% Ointment (apply 3 times daily) – PRN – 11/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Risperdal 1mg – PRN – 11/1, 2, 3, 4, 5; 7, 8, 9, 10, 11; 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Risperdal 1mg – PRN – 11/1, 2, 3, 4, 5; 7, 8, 9, 10, 11; 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (given 1 time)

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. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period. **Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **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.	• Imodium A-D 2mg (PRN) Individual #9 December 2010 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ativan 2mg – PRN – (Protocol) 12/24 (given 1 time) • Ativan 2mg – PRN – (Seizures) 12/24 (given 1 time) No evidence of documented Signs/Symptoms were found for the following PRN medication: • Ativan 2mg – PRN – (Protocol) 12/24 (given 1 time) • Ativan 2mg – PRN – (Seizures) 12/24 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Ativan 2mg – PRN – (Protocol) 12/24 (given 1 time) • Ativan 2mg – PRN – (Seizures) 12/24 (given 1 time) February 2011 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 200mg – PRN – 2/6 (given 1 time) Individual #13 December 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN)	

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	January 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN) February 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN) Individual #14 December 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN) January 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN) February 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Imodium A-D 2mg (PRN) Individual #16 December 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Enulose Syrup 30cc (PRN) • Seroquel ½ mg (PRN) • Acetaminophen 325mg (PRN) Medication Administration Records did not contain the circumstance for which the medication is to be used: • Dulcolax Suppository 10mg (PRN) No evidence of documented Signs/Symptoms were	

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.).	found for the following PRN medication: • Dulcolax Suppository 10mg – PRN – 12/1, 6, 9, 11, 14, 17, 20, 24, 27 & 31 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Dulcolax Suppository 10mg – PRN – 12/1, 6, 9, 11, 14, 17, 20, 24, 27 & 31 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Dulcolax Suppository 10mg – PRN – 12/1, 6, 9, 11, 14, 17, 20, 24, 27 & 31 (given 1 time) Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325mg (PRN) Medication Administration Records did not contain the circumstance for which the medication is to be used: • Acetaminophen 325mg (PRN) April 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Dulcolax Suppository 10mg – PRN – 4/1, 4, 7 & 10 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Dulcolax Suppository 10mg – PRN – 4/1, 4, 7 & 10 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Dulcolax Suppository 10mg – PRN – 4/1, 4, 7 &	

	10 (given 1 time) Individual #19 December 2010 During on-site survey Medication Administration Records were requested for months of December 2011, January, and February 2011. As of 4/15/2011, Medication Administration Records for December had not been provided. January 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Risperdal 2mg (PRN) February 2011 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Risperdal 2mg (PRN)	

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: E	Scope and Severity Rating: D
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **A. Duty To Report:** **(1)** All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. **(2)** All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property**,** unexpected and natural/expected deaths; and other reportable incidents to include: **(a)** an environmental hazardous condition, which creates an immediate threat to life or health; or **(b)** admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider. **(3)** All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. **B. Notification**: **(1) Incident Reporting:** Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.	Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 6 of 25 individuals. Individual #10 • Incident date 10/30/2010. Allegation was Abuse. Incident report was received 11/9/2010. Failure to Report. IMB Late & Failure Report indicated incident of Abuse & Neglect was "Confirmed." Individual #14 • Incident date 10/5/2010. Allegation was Neglect. Incident report was received 10/8/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #22 • Incident date 4/10/2010. Allegation was Neglect. Incident report was received 4/21/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #23 • Incident date 9/10/2010. Allegation was Neglect. Incident report was received 11/24/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #24 • Incident date 9/10/2010. Allegation was Neglect. Incident report was received 11/24/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #25 • Incident date 9/10/2010. Allegation was Neglect. Incident report was received 11/24/2010. Failure to Report. IMB Late & Failure Report indicated	**New & Repeat Findings:** Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 2 of 18 individuals. Individual #11 • Incident date 6/09/2011. Allegation was Neglect. Incident report was received 6/22/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Individual #26 • Incident date 7/30/2011. Allegation was Abuse. Incident report was received 8/01/2011. Failure to Report. IMB Late & Failure Report indicated incident of Abuse & Neglect was "Confirmed."

	incident of Neglect was “Confirmed.”	

Tag # 1A32 & 6L14 (CoP) ISP Implementation	Scope and Severity Rating: E	Scope and Severity Rating: D
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 11 of 21 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #15 • None supplied for 10/2010 - 3/2011 Individual #16 • None supplied for 12/2010 - 2/2011 Individual #17 • None supplied for 10/2010 - 3/2011 Individual #18 • None supplied for 10/2010 - 3/2011 Individual #19 • None supplied for 12/2010 - 2/2011 Individual #20 • None supplied for 10/2010 - 3/2011 Individual #21 • None supplied for 10/2010 - 3/2011 **Residential Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**:	**New & Repeat Findings:** Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 17 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Residential Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #2 • None found for 12/1-13, 2011 regarding: Live Outcome: "…will prepare a main dish once a week for the duration of his ISP year" • No data sheets for 12/2011 were found in the home specific to the Develop Relationship/Have Fun outcome: "… will invite a friend of his choice to play a sport twice a month." When DSP was asked for the documentation, DSP #118 and house manager attempted to locate documents and could not find them.

	Individual #2 • None found regarding: "I will make a visual activity calendar, weekly." Action Steps were not being completed at the required frequency indicated in the ISP for 4/1 – 11, 2011. • None found regarding: "I will participate in physical activities 3x a week." Action Steps were not being completed at the required frequency indicated in the ISP for 4/1 – 11, 2011. Individual #3 "(Individual #3) will work with staff to learn how to introduce her self." Per Live Outcome Statement this action step is to be completed daily. Action Steps were not being completed at the required frequency indicated in the ISP for 4/1, 5, 6, 9, 10 & 11, 2011. Individual #9 • "(Individual #9) will research where she'd like to go." is to be completed once weekly. Outcome was not being completed at the required frequency indicated in the ISP for 4/1 – 11, 2011. • "(Individual #9) will check and save, if necessary, money to afford her trip." is to be completed once weekly. Outcome was not being completed at the required frequency indicated in the ISP for 4/1 – 11, 2011. Individual #11 • None found regarding: "Everyday (Individual #11) will follow a daily schedule using pictures for the next six months." Action Steps were not being completed at the required frequency indicated in the ISP for 4/1 – 11, 2011.	

Tag # 5I44 AH Reimbursement	Scope and Severity Rating: C	Scope and Severity Rating: A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 13 of 15 individuals. Individual #1 December 2010 • The Agency billed 446 units of Adult Habilitation from 12/01/2010 through 12/24/2010. Documentation received accounted for 371 units. Individual #2 January 2010 • The Agency billed 73 units of Adult Habilitation from 01/16/2011 through 01/21/2011. Documentation received accounted for 65 units. Individual #4 December 2010 • The Agency billed 233 units of Adult Habilitation from 12/01/2010 through 12/11/2010. Documentation received accounted for 232 units. January 2011 • The Agency billed 63 units of Adult Habilitation from 01/28/2011 through 01/30/2011. The above mentioned dates were consecutively listed with the exception of 01/30/2011. Documentation did not contain a date on 01/30/2011 to justify billing. Individual #5 • The Agency billed 241 units of Adult Habilitation on 12/01/2010 through 12/11/2010. The above mentioned dates were consecutively listed with the exception of 12/02/2011. Documentation did not contain a date to justify billing on 12/02/2011. Individual #6 December 2010 • The Agency billed 10 units of Adult Habilitation on 12/01/2010. No documentation found to justify	**New & Repeat Findings:** Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 2 of 12 individuals. Individual #4 November 2011 • The Agency billed 297 units of Adult Habilitation (T2021 U1) from 11/02/2011 through 11/14/2011. Documentation received accounted for 293 units. • The Agency billed 57 units of Adult Habilitation (T2021 U1) from 11/28/2011 through 11/30/2011. No Documentation received to justify 57 units billed. Individual #14 November 2011 • The Agency billed 88 units of Adult Habilitation (T2021 U1) from 11/06/2011 through 11/10/2011. Documentation received accounted for 84 units. • The Agency billed 46 units of Adult Habilitation (T2021 U1) from 11/28/2011 through 11/30/2011. No Documentation received to justify 46 units billed.

Services is in 15-minute increments hour. The rate is based on the individual's level of care. **B. Billable Activities** (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours. (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours	billing. • The Agency billed 212 units of Adult Habilitation from 12/05/2010 through 12/19/2011. Documentation received accounted for 188 units. January 2011 • The Agency billed 39 units of Adult Habilitation from 01/04/2011 through 01/06/2011. Documentation received accounted for 35 units. • The Agency billed 290 units of Adult Habilitation from 01/08/2011 through 01/26/2011. Documentation received accounted for 273 units. • The Agency billed 34 units of Adult Habilitation from 01/28/2011 through 01/30/2011. Documentation received accounted for 27 units. Individual #7 December 2010 • The Agency billed 399 units of Adult Habilitation from 12/01/2010 through 12/25/2011. Documentation received accounted for 395 units. • The Agency billed 109 units of Adult Habilitation from 12/26/2010 through 12/31/2011. Documentation received accounted for 105 units. Individual #8 December 2010 • The Agency billed 150 units of Adult Habilitation from 12/04/2010 through 12/11/2010. The above mentioned dates were consecutively listed with the exception of 12/07/2010. Documentation did not contain a date to justify billing on 12/07/2010. • The Agency billed 181 units of Adult Habilitation from 12/13/2010 through 12/22/2010. The above mentioned dates were consecutively listed with the exception of 12/16/2010. Documentation did not contain a date to justify billing on 12/16/2010.	

	January 2011 • The Agency billed 105 units of Adult Habilitation from 01/02/2011 through 01/06/2011. Documentation received accounted for 87 units. • The Agency billed 60 units of Adult Habilitation from 01/13/2011 through 01/16/2011. Documentation received accounted for 59 units. Individual #9 December 2010 • The Agency billed 20 units of Adult Habilitation from 12/06/2010 through 12/08/2010. Documentation received accounted for 18 units. • The Agency billed 51 units of Adult Habilitation from 12/17/2010 through 12/20/2010. The above mentioned dates were consecutively listed with the exception of 12/17/2010. Documentation did not contain a date to justify billing on 12/17/2010. January 2011 • The Agency billed 19 units of Adult Habilitation from 01/13/2011 through 01/14/2011. The above mentioned dates were consecutively listed with the exception of 01/13/2011. Documentation did not contain a date to justify billing on 01/13/2011. • The Agency billed 25 units of Adult Habilitation from 01/30/2011 through 01/31/2011. Documentation received accounted for 10 units. February 2011 • The Agency billed 15 units of Adult Habilitation from 02/09/2011 through 2/10/2011. Documentation received accounted for 9 units. Individual #10 December 2010 • The Agency billed 46 units of Adult Habilitation from 12/28/2010 through 12/31/2010.	

	Documentation received accounted for 31 units. January 2011 • The Agency billed 135 units of Adult Habilitation from 01/01/2011 through 01/12/2011. Documentation received accounted for 124 units. • The Agency billed 85 units of Adult Habilitation from 01/13/2011 through 01/18/2011. Documentation received accounted for 80 units. • The Agency billed 25 units of Adult Habilitation from 1/26/2011 through 01/27/2011. Documentation received accounted for 22 units. February 2011 • The Agency billed 65 units of Adult Habilitation from 02/02/2011 through 2/07/2011. Documentation received accounted for 63 units. • The Agency billed 20 units of Adult Habilitation from 02/14/2011 through 2/17/2011. Documentation received accounted for 12.25 units. • The Agency billed 114 units of Adult Habilitation from 02/19/2011 through 02/26/2011. Documentation received accounted for 103 units. Individual #11 February 2011 • The Agency billed 63 units of Adult Habilitation from 02/05/2011 through 02/09/2011. The above mentioned dates were consecutively listed with the exception of 02/06/2011 & 02/07/2011. Documentation did not contain a date to justify billing on 02/06/2011 & 02/07/2011. Individual $12 December 2010 • The Agency billed 9 units of Adult Habilitation on 12/09/2010. Documentation did not contain an	

	end time to justify billing. • The Agency billed 54 units of Adult Habilitation from 12/30/2010 through 12/31/2010. No documentation found to justify billing. Individual #13 December 2010 • The Agency billed 113 units of Adult Habilitation from 12/26/2010 through 12/31/2010. Documentation received accounted for 110 units. January 2011 • The Agency billed 169 units of Adult Habilitation from 01/01/2011 through 01/10/2011. Documentation received accounted for 168 units. • The Agency billed 121 units of Adult Habilitation from 01/23/2011 through 01/30/2011. Documentation received accounted for 97 units. February 2011 • The Agency billed 70 units of Adult Habilitation from 02/02/2011 through 02/07/2011. Documentation received accounted for 46 units. • The Agency billed 61 units of Adult Habilitation from 02/09/2011 through 02/11/2011. The above mentioned dates were consecutively listed with the exception of 02/09/2011. Documentation did not contain a date to justify billing on 02/09/2011. • The Agency billed 84 units of Adult Habilitation from 02/13/2011 through 02/18/2011. Documentation received accounted for 77 units. Individual #14 December 2010 • The Agency billed 54 units of Adult Habilitation from 12/11/2010 through 12/13/2010. No documentation found to justify billing.	

	• The Agency billed 47 units of Adult Habilitation from 12/15/2010 through 12/19/2010. Documentation received accounted for 17 units. January 2011 • The Agency billed 72 units of Adult Habilitation from 01/13/2011 through 01/17/2011. Documentation received accounted for 62 units. • The Agency billed 90 units of Adult Habilitation from 01/19/2011 through 01/26/2011. Documentation received accounted for 26 units. Individual #16 December 2010 • The Agency billed 18 units of Adult Habilitation on 12/14/2010. Documentation received accounted for 17 units.	

Tag # 6L14 Residential Case File	Scope and Severity Rating: E	Scope and Severity Rating: E
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 16 of 21 Individuals receiving Family Living Services & Supported Living Services. The following was not found, incomplete and/or not current: • **Current Emergency & Personal Identification Information** ° Did not contain current address Information (#12) ° Did not contain current home phone Information (#12) • Positive Behavioral Plan (#1, 3, 12 & 20) • Positive Behavioral Crisis Plan (#2, 9, 10, 11, 19 & 20) • Speech Therapy Plan (#1, 4, 7 & 8) • Occupational Therapy Plan (#2 & 18) • **Special Health Care Needs** ° Meal Time Plan (#4 & 21) ° Nutritional Plan (#16 & 21) ° Oral Hygiene plan of care (#9) • **Health Care Plans** ° Aspiration (#3 & 9) ° Asthma (#11) ° Alteration in thought process (#9) ° Chronic pain (#3) ° PRN Ativan 2mg Agitation protocol (#9) ° Skin Integrity (#14) • **Crisis Plan** ° Diabetes (#7) ° Gastrointestinal (#3, 7 &14)	**New & Repeat Findings:** Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 7 of 17 Individuals receiving Family Living Services & Supported Living Services. The following was not found, incomplete and/or not current: • Positive Behavioral Crisis Plan (#3 & 9) • Speech Therapy Plan (#18) • Physical Therapy Plan (#14) • Occupational Therapy Plan (#18) • **Special Health Care Needs** ° Nutritional Plan (#7 & 14) ° Comprehensive Aspiration Risk Management Plan (#14) • **Health Care Plans** ° Aspiration (#14) ° BMI (#21) ° Skin and Wound (#16) ° Vagus Nerve Stimulation (VNS) (#9) • **Crisis Plan/Medical Emergency Response Plans** ° Diabetes (#21) ° Aspiration (#14) ° Vagus Nerve Stimulation (VNS) (#9) • **Progress Notes/Daily Contacts Logs:** ° Individual #9 - None found for 12/1 – 13, 2011 ° Individual #18 - None found for 12/1 – 14, 2011

(9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.	◦ Hemo chromatosis Factor (#7) ◦ Hypertension (#7) • **Progress Notes/Daily Contacts Logs:** ◦ Individual #16 - None found for 4/1 – 12, 2011	

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: E	Scope and Severity Rating: D
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has: (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 11 of 17 Supported Living & Family Living residences. The following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift (#7) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#3, 6, 10, 11, 13 & 14) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#3, 6,13 & 14) Note: • Individuals #10 & 11 share a residence **Family Living Requirements:** • Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#18) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each	**Repeat Finding:** Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 1 of 12 Supported Living & Family Living residences. The following items were not found, not functioning or incomplete: **Family Living Requirements:** • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#16)

	individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#20) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#15, 16 & 20)	

Tag # 6L27 FL Reimbursement	Scope and Severity Rating: C	Scope and Severity Rating: B
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** A. **General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. B. **Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES**	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 7 of 7 individuals. Individual #15 December 2010 • The Agency billed 31 units of Family Living from 12/01/2010 through 12/31/2010. No documentation was found for 12/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. January 2011 • The Agency billed 31 units of Family Living from 01/01/2011 through 01/31/2010. No documentation was found for 01/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. February 2011 • The Agency billed 15 units of Family Living from 02/01/2011 through 02/15/2011. No documentation was found for 02/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14 & 15 to justify billing. Individual #16 December 2010 • The Agency billed 31 units of Family Living from 12/01/2010 through 12/31/2010. No documentation was found for 12/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. January 2011 • The Agency billed 31 units of Family Living from 01/01/2011 through 01/31/2010. No	**New & Repeat Finding:** Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 2 of 6 individuals. Individual #17 November 2011 • The Agency billed 30 units of Family Living (T2033) on 11/01/2011 through 11/30/2011. Documentation did not contain end time on 11/4 & 11/27 to justify 2 units billed. Units accounted for were 28. • The Agency billed 30 units of Family Living (T2033) on 11/01/2011 through 11/30/2011. Documentation did not contain start time and end time on 11/06 & 11/19 to justify 2 units billed. Units accounted for were 28. Individual #18 November 2011 • The Agency billed 30 units of Family Living (T2033) on 11/01/2011 through 11/30/2011. No documentation received on 11/16 & 11/29 to justify 2 units billed. Units accounted for were 28.

B. Reimbursement for Family Living Services (1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year. (2) Billable Activities shall include: (a) Direct support provided to an individual in the residence any portion of the day; (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and (c) Any other activities provided in accordance with the Scope of Services. (3) Non-Billable Activities shall include: (a) The Family Living Services Provider Agency may not bill the for room and board; (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and (c) Family Living services may not be billed for the same time period as Respite. (d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **Chapter 6 - COMMUNITY LIVING SERVICES** **III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **C. Service Limitations**. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore, a specified	documentation was found for 01/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. February 2011 • The Agency billed 20 units of Family Living from 02/01/2011 through 02/20/2011. No documentation was found for 02/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 & 20 to justify billing. Individual #17 December 2010 • The Agency billed 31 units of Family Living from 12/01/2010 through 12/31/2010. No documentation was found for 12/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. January 2011 • The Agency billed 31 units of Family Living from 01/01/2011 through 01/31/2010. No documentation was found for 01/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. February 2011 • The Agency billed 17 units of Family Living from 02/01/2011 through 02/20/2011. No documentation was found for 02/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16 & 17 to justify billing. Individual #18 December 2010 • The Agency billed 31 units of Family Living from 12/01/2010 through 12/31/2010. No documentation was found for 12/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17,	

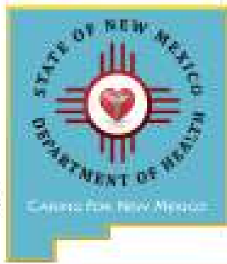
deduction to the daily rate for Family Living shall be made for each unit of respite received. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **DEFINITIONS SUBSTITUTE CARE** means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider. **RESPITE** means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.	18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. January 2011 • The Agency billed 31 units of Family Living from 01/01/2011 through 01/31/2010. No documentation was found for 01/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. February 2011 • The Agency billed 20 units of Family Living from 02/01/2011 through 02/20/2011. No documentation was found for 02/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 & 20 to justify billing. Individual #19 December 2010 • The Agency billed 31 units of Family Living from 12/01/2010 through 12/31/2010. No documentation was found for 12/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. January 2011 • The Agency billed 31 units of Family Living from 01/01/2011 through 01/31/2010. No documentation was found for 01/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. February 2011 • The Agency billed 10 units of Family Living from 02/01/2011 through 02/10/2011. No documentation was found for 02/01, 02, 03, 04, 05, 06, 07, 08, 09 & 10 to justify billing. • The Agency billed a total of 1 unit of Family Living	

	Services on 02/12/2010. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Documentation only stated "with Respite". • The Agency billed a total of 1 unit of Family Living Services on 02/20/2010. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Documentation only stated "with Respite". • The Agency billed a total of 1 unit of Family Living Services on 02/25/2010. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Documentation only stated "with Respite". • The Agency billed a total of 1 unit of Family Living Services on 02/26/2010. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Documentation only stated "with Respite". • The Agency billed a total of 1 unit of Family Living Services on 02/27/2010. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Documentation only stated "with Respite". Individual #20 December 2010 • The Agency billed 31 units of Family Living from 12/01/2010 through 12/31/2010. No documentation was found for 12/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. January 2011 • The Agency billed 31 units of Family Living from 01/01/2011 through 01/31/2010. No documentation was found for 01/01, 02, 03, 04,	

	05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. February 2011 • The Agency billed 23 units of Family Living from 02/01/2011 through 02/23/2011. No documentation was found for 02/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22 & 23 to justify billing. • The Agency billed a total of 5 units of Family Living Services on 02/24/2011 through 02/28/2011. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Documentation was a cut and paste description of the same narrative for each day. Individual #21 December 2010 • The Agency billed 31 units of Family Living from 12/01/2010 through 12/31/2010. No documentation was found for 12/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. January 2011 • The Agency billed 31 units of Family Living from 01/01/2011 through 01/31/2010. No documentation was found for 01/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. February 2011 The Agency billed 16 units of Family Living from 02/01/2011 through 02/16/2011. No documentation was found for 02/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15 & 16 to justify billing.	

Standard of Care	April 11 – 15, 2011 Deficiencies	December 13 – 15, 2011 Verification Survey – New and Repeat Deficiencies
Tag # 1A06 Provider Agency Policy and Procedure Requirements	Scope and Severity Rating: A	Completed
Tag # 1A08 Agency Case File	Scope and Severity Rating: E	Completed
Tag # 1A08.1 Agency Case File - Progress Notes	Scope and Severity Rating: B	Completed
Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E	Completed
Tag # 1A11.1 (CoP) Transportation Training	Scope and Severity Rating: D	Completed
Tag # 1A15.2 & 5I09 - Healthcare Documentation	Scope and Severity Rating: D	Completed
Tag # 1A20 DSP Training Documents	Scope and Severity Rating: D	Completed
Tag # 1A22 Staff Competence	Scope and Severity Rating: D	Completed
Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: D	Completed
Tag # 1A28.1 (CoP) Incident Mgt. System - Personnel Training	Scope and Severity Rating: E	Completed
Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: D	Completed
Tag # 1A33.1 Board of Pharmacy – Lic	Scope and Severity Rating: A	Completed
Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D	Completed
Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E	Completed
Tag # 5I25 SE Reimbursement	Scope and Severity Rating: B	Completed
Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: F	Completed
Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: D	Completed

Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Scope and Severity Rating: B	Completed
Tag #6L26 SL Reimbursement	Scope and Severity Rating: B	Completed



SUSANA MARTINEZ, GOVERNOR CATHERINE D. TORRES, M.D., CABINET SECRETARY

Date: May 15, 2012

To: Jon Hellebust, Executive Director

Provider: LLCP NMDOH
Address: 445 Camino Del Ray, Suite A
State/Zip: Los Lunas, New Mexico 87031
E-mail Address: jon.hellebust@state.nm.us

Region: Metro
Routine Survey: April 11 – 15, 2011
Verification Survey: December 13 – 15, 2011
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation & Supported Employment)
Survey Type: Verification

Dear Mr. Hellebust;

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,

Scott Good
QMB Deputy Chief
Quality Management Bureau/DHI

Q.12.4.DDW. D1977.5.001.VER.09.136

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