Date:	December 12, 2011
To:	Ms. Chitra Roy, Executive Director
Provider:	Optihealth, Inc.
Address:	4620 Jefferson Lane Suite A
State/Zip:	Albuquerque, NM 87109
E-mail Address:	Optihealth9999@aol.com
Region:	Metro
Original Survey:	April 25 - 28, 2011
Verification Survey:	November 21 - 22, 2011
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Community Living (Supported Living & Independent Living) & Community Inclusion (Adult Habilitation)
Survey Type:	Verification
Team Leader:	Maurice Gonzales, BS Health Ed. Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Stephanie Berenger, MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Roy;

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/DDSD regarding the Routine Survey on ***April 25 – 28, 2011.***

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,

Maurice Gonzales, BS Health Ed.

Maurice Gonzales, BS Health Ed.
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	November 21, 2011
Present:	**Optihealth, Inc.** Chitra Roy, Director Christy Chavez, Administrative Assistant **DOH/DHI/QMB** Maurice Gonzales, BS Health Ed. Team Lead/Healthcare Surveyor Stephanie Berenger, MBA, Healthcare Surveyor Jennifer Bruns, BSW, Healthcare Surveyor
Exit Conference Date:	November 22, 2011
Present:	**Optihealth, Inc.** Chitra Roy, Director Christy Chavez, Administrative Assistant Susan White, Office Manager Brenda Allen, Service Coordinator Jeanette Benjamin, Service Coordinator **DOH/DHI/QMB** Maurice Gonzales, BS Health Ed. Team Lead/Healthcare Surveyor Stephanie Berenger, MBA, Healthcare Surveyor Jennifer Bruns, BSW, Healthcare Surveyor
Total Homes Visited	Number: 7
❖ Supported Homes Visited	Number: 7
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 8 1 - *Jackson* Class Members 7 - Non-*Jackson* Class Members 7 - Supported Living 1 - Independent Living 4 - Adult Habilitation
Records Reviewed (Persons Served)	Number: 4 (The other 4 Individuals did not have deficiencies that required review during the verification survey)
Direct Service Professionals Record Review	Number: 109
Service Coordinator Record Review	Number: 2
Administrative Files Reviewed	• Billing Records • Medical Records • Incident Management Records • Personnel Files • Training Records • Agency Policy and Procedure • Caregiver Criminal History Screening Records • Employee Abuse Registry • Human Rights Notes and/or Meeting Minutes • Evacuation Drills • Quality Assurance / Improvement Plan

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

Attachment B

QMB Scope and Severity Matrix

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

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

Scope and Severity Definitions:

- Isolated:

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

- Pattern:

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

- Widespread:

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

QMB Determinations of Compliance

- "Substantial Compliance with Conditions of Participation"

The QMB determination of "Substantial Compliance with Conditions of Participation" indicates that a provider is in substantial compliance with all 'Conditions of Participation' and other standards and regulations. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Substantial Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation.

- "Non-Compliance with Conditions of Participation"

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

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

- "Sub-Standard Compliance with Conditions of Participation":

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

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

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

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: **Optihealth, Inc. - Metro Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living & Independent Living) & Community Inclusion (Adult Habilitation)
Monitoring Type: Verification Survey
Original Survey: **April 25 - 28, 2011**
Verification Survey: **November 21-22, 2011**

Standard of Care	April 25 – 28, 2011 Deficiencies	November 21-22, 2011 Verification Survey – New and Repeat Deficiencies
Tag # 1A28.1 (CoP) Incident Mgt. System - Personnel Training	**Scope & Severity Rating: E**	**Scope and Severity Rating: D**
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed	Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 23 of 84 Agency Personnel. **Direct Service Professional Personnel (DSP):** • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#40, 41, 42, 51, 59, 71, 75, 77, 79, 85, 86, 91, 92, 93, 95, 99, 112, 114, 116 & 119) **Service Coordination Personnel (SC):** • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (# 122 & 123) **When Direct Service Professionals were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:** • DSP #107 stated, “I don’t know”	**New Findings & Repeat:** Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 1 of 111 Agency Personnel. **Direct Service Professional Personnel (DSP):** • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#156)

health care facility or community based service provider to the penalties provided for in this rule. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007** **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.		

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E	Scope and Severity Rating: D
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a)Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6 on	Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 4 of 8 individuals receiving Community Living Services. The following was not found, incomplete and/or not current: • **Dental Exam** ◦ Individual #1 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #3 - As indicated by collateral documentation reviewed, exam was completed on 8/31/2010. Follow-up was to be completed in 6 months. No evidence of follow-up found. • **Vision Exam** ◦ Individual #1 - As indicated by collateral documentation reviewed, exam was completed on 6/5/2009. Follow-up was to be completed in 12 months. No evidence of follow-up found. • **Auditory Exam** ◦ Individual #2 - As indicated by collateral documentation reviewed, exam was completed on 1/19/2010. Follow-up was to be completed in 12 months. No evidence of follow-up found. ▪ **Cholesterol & Blood Glucose** ◦ Individual #2 - As indicated by collateral documentation reviewed, lab work was ordered on 3/24/2010. No evidence of lab results were found. • **Tardive Dyskinesia Screenings** ◦ None found 7/2010 - 1/2011 for Risperidone and Reglan (Individual #3)	**Repeat Finding:** Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 1 of 8 individuals receiving Community Living Services. The following was not found, incomplete and/or not current: • **Swallow Study** ◦ Individual #3 - As indicated by collateral documentation reviewed, exam was scheduled for 2/4/2011. No evidence of exam results were found.

the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT. (5) That the physical property and grounds are free of hazards to the individual's health and safety. (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following: (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine). **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	• **Swallow Study** ◦ Individual #3 - As indicated by collateral documentation reviewed, exam was scheduled for 2/4/2011. No evidence of exam results were found. • **Psychological Assessment** ◦ Individual #5 - As indicated by collateral documentation reviewed, exam was scheduled for 3/21/2011. No evidence of exam results ere found.	

results of laboratory and radiology procedures or progress following therapy or treatment.		

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: F	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 7 of 7 Supported Living residences. The following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#2) • 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 (#2, 3, 4, 5, 6, 7 & 8) • 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 (#2)	**Repeat Finding**: Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 1 of 7 Supported Living residences. The following items were not found, not functioning or incomplete: **Supported 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 (#2)

Standard of Care	April 25 – 28, 2011 Deficiencies	November 21-22, 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: B	Completed
Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E	Completed
Tag # 1A09.1 Medication Delivery - PRN Medication	Scope and Severity Rating: E	Completed
Tag # 1A11.1 (CoP) Transportation Training	Scope and Severity Rating: E	Completed
Tag # 1A15.2 & 5I09 - Healthcare Documentation	Scope and Severity Rating: E	Completed
Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E	Completed
Tag # 1A22 Staff Competence	Scope and Severity Rating: D	Completed
Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D	Completed
Tag # 1A26 (CoP) COR/EAR	Scope and Severity Rating: D	Completed
Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: E	Completed
Tag # 1A37 Individual Specific Training	Scope and Severity Rating: E	Completed
Tag #1A39 – Assistive Technology & Adaptive Equipment	Scope and Severity Rating: A	Completed
Tag # 5I44 AH Reimbursement	Scope and Severity Rating: B	Completed
Tag # 6L14 Residential Case File	Scope and Severity Rating: F	Completed

Date: May 14, 2012

To: Ms. Chitra Roy, Executive Director
Provider: Optihealth, Inc.
Address: 4620 Jefferson Lane Suite A
State/Zip: Albuquerque, NM 87109

E-mail Address: Optihealth9999@aol.com

Region: Metro
Original Survey: April 25 - 28, 2011
Verification Survey: November 21 - 22, 2011
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living & Independent Living) & Community Inclusion (Adult Habilitation)

Dear Ms. Roy:

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

Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.12.4.DDW. D1889.5.001.VER.09.135