Dear Mr. Gaur;

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

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

**Partial Compliance with Conditions of Participation**
The following tags are identified as Condition of Participation Level Deficiencies:
- Tag # 1A08.2 Healthcare Requirements
- Tag # 1A15.2 and IS09 /5I09 Healthcare Documentation
- Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training
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.

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

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

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

1. **Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator**
   1170 North Solano Suite D Las Cruces, New Mexico 88001

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

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

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

**Billing Deficiencies:**
If you have deficiencies noted in this report of findings under the Service Domain: Medicaid Billing/Reimbursement, you must complete a Void/Adjust claims or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, **though this is not the preferred method of payment**. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: Julie Ann Hill-Clapp
HSD/OIG
Program Integrity Unit
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Or if using UPS, FedEx, DHL (courier mail) send to physical address at:

Attention: Julie Ann Hill-Clapp
HSD/OIG
Program Integrity Unit
2025 S. Pacheco Street
Santa Fe, New Mexico 87505

Please be advised that there is a one-week lag period for applying payments received by check to Voided/Adjusted claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.
Request for Informal Reconsideration of Findings (IRF):
If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

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

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

Please call the Plan of Correction Coordinator Amanda Castaneda at 575-373-5716 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Nicole Brown, MBA

Nicole Brown, MBA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: August 24, 2015

Present: **People Center Services, LLC**
Loretta Lindahl, Manager
Rito Rodriguez, Direct Support Staff

**DOH/DHI/QMB**
Nicole Brown, MBA, Team Lead/Healthcare Surveyor
Jesus Trujillo, RN, Healthcare Surveyor
Stephanie Roybal, BA, Healthcare Surveyor

Exit Conference Date: August 28, 2015

Present: **People Center Services, LLC**
Manish Gaur, Director
Cheryl Juntunen, Service Coordinator
Loretta Lindahl, Manager

**DOH/DHI/QMB**
Nicole Brown, MBA, Team Lead/Healthcare Surveyor
Jesus Trujillo, RN, Healthcare Surveyor

**DDSD - NE Regional Office**
Angela Pacheco, Regional Manager, via telephone

Administrative Locations Visited Number: 1
Total Sample Size Number: 9
1 - Jackson Class Members
8 - Non-Jackson Class Members

1 - Adult Habilitation
3 - Customized Community Supports
6 - Community Integrated Employment Services

Persons Served Records Reviewed Number: 9
Persons Served Interviewed Number: 6
Persons Served Observed Number: 3 (Three individuals were unavailable during on-site survey)

Direct Support Personnel Interviewed Number: 3
Direct Support Personnel Records Reviewed Number: 6
Service Coordinator Records Reviewed Number: 2

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
• Individual Medical and Program Case Files, including, but not limited to:
  o Individual Service Plans
  o Progress on Identified Outcomes
  o Healthcare Plans
  o Medication Administration Records
  o Medical Emergency Response Plans
  o Therapy Evaluations and Plans
  o Healthcare Documentation Regarding Appointments and Required Follow-Up
  o Other Required Health Information

• Internal Incident Management Reports and System Process / General Events Reports
• Personnel Files, including nursing and subcontracted staff
• Staff Training Records, Including Competency Interviews with Staff
• Agency Policy and Procedure Manual
• Caregiver Criminal History Screening Records
• Consolidated Online Registry/Employee Abuse Registry
• Quality Assurance / Improvement Plan

CC: Distribution List:  DOH - Division of Health Improvement
                  DOH - Developmental Disabilities Supports Division
                  DOH - Office of Internal Audit
                  HSD - Medical Assistance Division
                  MFEAD – NM Attorney General
Provider Instructions for Completing the QMB Plan of Correction (POC) Process

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

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

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

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

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

Instructions for Completing Agency POC:

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

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

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

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

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

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

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

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

2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.

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

4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
   a. Electronically at AmandaE.Castaneda@state.nm.us (preferred method)
   b. Fax to 575-528-5019, or
   c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001

5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.

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

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

**POC Document Submission Requirements**

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

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

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

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

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

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

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

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

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

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

Conditions of Participation (CoPs)

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

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

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

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

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

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

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

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

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

**Service Domain: Plan of Care**
Condition of Participation:
5. **ISP Implementation**: Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

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

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

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

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

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

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

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

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

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

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.
<table>
<thead>
<tr>
<th>Service Domain: Service Plans: ISP Implementation – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tag # 1A08 Agency Case File</td>
</tr>
<tr>
<td>Standard of Care</td>
</tr>
<tr>
<td>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 8 of 9 individuals.</td>
</tr>
<tr>
<td>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td>• ISP budget forms MAD 046  ° Not Found (#2, 8, 9) (No POC required as budget is delayed due to Third Party Assessor #2, 8, 9)</td>
</tr>
<tr>
<td>• Current Emergency and Personal Identification Information  ° None Found (#2)</td>
</tr>
<tr>
<td>• Did not contain names and phone numbers of relatives, or guardian or conservator. (#8)</td>
</tr>
<tr>
<td>• ISP Signature Page (#9)</td>
</tr>
<tr>
<td>• Positive Behavioral Support Plan (#7)</td>
</tr>
</tbody>
</table>

Agency: People Center Services, LLC – Northeast Region
Program: Developmental Disabilities Waiver
Monitoring Type: Routine Survey
Survey Date: August 24 – 28, 2015
1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD.

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

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

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

**Chapter 13 (IMLS) 2. Service Requirements:**
**C. Documents to be maintained in the agency administrative office, include:** (This is not an all-inclusive list refer to standard as it includes other items)
- Emergency contact information;
- Personal identification;
- ISP budget forms and budget prior authorization;
- ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan (PBSP), Behavior Crisis Intervention Plan (BCIP), or other relevant behavioral plans,
- Medical Emergency Response Plan (MERP),
- Speech Therapy Plan (#5, 8, 9)
- Occupational Therapy Plan (#7)
- Documentation of Guardianship/Power of Attorney (#1, 3, 4, 5)
| Healthcare Plan, Comprehensive Aspiration Risk Management Plan (CARMP), and Written Direct Support Instructions (WDSI);  
| • Dated and signed evidence that the individual has been informed of agency grievance/complaint procedure at least annually, or upon admission for a short term stay;  
| • Copy of Guardianship or Power of Attorney documents as applicable;  
| • Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays;  
| • Written consent by relevant health decision maker and primary care practitioner for self-administration of medication or assistance with medication from DSP as applicable;  
| • Progress notes written by DSP and nurses;  
| • Signed secondary freedom of choice form;  
| • Transition Plan as applicable for change of provider in past twelve (12) months.  

**DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director’s Release: Consumer Record Requirements eff. 11/1/2012**

**III. Requirement Amendments(s) or Clarifications:**

**A.** All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director’s release.

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

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

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

1. Emergency contact information, including the individual’s address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician’s name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;
2. The individual’s complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);
3. Progress notes and other service delivery documentation;
4. Crisis Prevention/Intervention Plans, if there are any for the individual;
5. A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;
6. When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and
7. Case records belong to the individual receiving services and copies shall be provided to the individual upon request.
8. The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:
(a) Complete file for the past 12 months;
(b) ISP and quarterly reports from the current and prior ISP year;
(c) Intake information from original admission to services; and 
(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.

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

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
| Tag # 1A08.1 | Agency Case File - Progress Notes | Standard Level Deficiency | Provider:
State your Plan of Correction for the deficiencies cited in this tag here: → |
|--------------|---------------------------------|---------------------------|--------------------------------------------------------------------------------|
| Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 Chapter 5 (CIES) 3. Agency Requirements: 6. Reimbursement A. 1. ...Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record... | Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 1 of 9 Individuals. Review of the Agency individual case files revealed the following items were not found: Customized Community Services Notes/Daily Contact Logs • Individual #8 - None found for 07/08/2015 – 07/14/2015 | Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
| Chapter 6 (CCS) 3. Agency Requirements: 4. Reimbursement A. Record Requirements 1. ...Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record... | | |
| Chapter 7 (CIHS) 3. Agency Requirements: 4. Reimbursement A. 1. ...Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record... | | |
| Chapter 11 (FL) 3. Agency Requirements: 4. Reimbursement A. 1. ...Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record... | | |
| Chapter 12 (SL) 3. Agency Requirements: 2. Reimbursement A. 1. Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record... | | |


Survey Report #: Q.16.1.DDW.242907870.2.RTN.01.15.266

Page 18 of 78
Chapter 13 (IMLS) 3. Agency Requirements:
4. Reimbursement A. 1. …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record…

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

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

(3) Progress notes and other service delivery documentation;
**Standard of Care** | **Deficiencies** | **Agency Plan of Correction, On-going QA/QI and Responsible Party** | **Date Due**
---|---|---|---

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

<table>
<thead>
<tr>
<th>Tag # 1A11.1 Transportation Training</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
</table>

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

Training Requirements for Direct Service Agency Staff Policy **Eff. Date:** March 1, 2007

**II. POLICY STATEMENTS:**

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

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

**NMAC 7.9.2 F. TRANSPORTATION:**

(1) Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training

Based on record review and interview, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 4 of 6 Direct Support Personnel.

No documented evidence was found of the following required training:

- Transportation (DSP #200, 201, 203, 204)

When DSP were asked if they had received transportation training including training on the agency’s policies and procedures following was reported:

- DSP 204 stated “No, but I have with R-Way.”

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

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

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

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

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

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

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


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

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

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

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

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

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
### Tag # 1A20
**Direct Support Personnel Training**

<table>
<thead>
<tr>
<th>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Individuals shall receive services from competent and qualified staff.</td>
</tr>
<tr>
<td>B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</td>
</tr>
<tr>
<td>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</td>
</tr>
<tr>
<td>D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.</td>
</tr>
<tr>
<td>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</td>
</tr>
<tr>
<td>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</td>
</tr>
<tr>
<td>G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.</td>
</tr>
<tr>
<td>H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.</td>
</tr>
<tr>
<td>I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 3 of 6 Direct Support Personnel.</td>
</tr>
</tbody>
</table>

Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:

- Foundation for Health and Wellness (DSP #205)
- First Aid (DSP #210, 203)
- CPR (DSP #210, 203)

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

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


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

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

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

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

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

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
### Tag # 1A22
#### Agency Personnel Competency

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
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</thead>
<tbody>
<tr>
<td>Based on interview, the Agency did not ensure training competencies were met for 2 of 3 Direct Support Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>When DSP were asked if they received training on the Individual’s Individual Service Plan and what the plan covered, the following was reported:</strong></td>
<td></td>
</tr>
<tr>
<td>• DSP #204 stated, “Not through People Centered Services, through another agency.” (Individual #3)</td>
<td></td>
</tr>
<tr>
<td><strong>When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:</strong></td>
<td></td>
</tr>
<tr>
<td>• DSP #204 stated, “Yes, I don’t know his therapist would.” DSP #204 could not describe what the plan states, yet according to the Individual Specific Training Section of the ISP the Individual requires a Positive Behavioral Supports Plan and DSP are to be trained by the Behavior Therapist. (Individual #3)</td>
<td></td>
</tr>
<tr>
<td><strong>When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:</strong></td>
<td></td>
</tr>
<tr>
<td>• DSP #202 stated, “No.” As indicated by the Individual Specific Training section of the ISP indicates the Individual requires Medical Emergency Response Plan for Seizures. (Individual #2)</td>
<td></td>
</tr>
</tbody>
</table>

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**Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013**

**CHAPTER 5 (CIES) 3. Agency Requirements**

- **G. Training Requirements:** 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.

**CHAPTER 6 (CCS) 3. Agency Requirements**

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

**CHAPTER 7 (CIHS) 3. Agency Requirements**

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

CHAPTER 11 (FL) 3. Agency Requirements
B. Living Supports - Family Living Services
Provider Agency Staffing Requirements: 3. Training:
A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and
Documentation for DDSD Training Requirements.
B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc.), information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

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

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
<table>
<thead>
<tr>
<th>Tag # 1A25</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Caregiver History Screening</td>
<td>Based on record review, the Agency did not maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 1 of 6 Agency Personnel. The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings: Direct Support Personnel (DSP):</td>
<td></td>
</tr>
<tr>
<td>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</td>
<td>• #203 – Date of hire 10/14/2014.</td>
<td></td>
</tr>
<tr>
<td>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. (1) In cases where the criminal history record lists an arrest for a crime that would constitute a disqualifying conviction and no final disposition is listed for the arrest, the department will attempt to notify the applicant, caregiver or hospital caregiver and request information from the applicant, caregiver or hospital caregiver within timelines set forth in the department's notice regarding the final disposition of the arrest. Information requested by the department may be evidence, for example, a certified copy of an acquittal, dismissal or conviction of a lesser included crime. (2) An applicant’s, caregiver’s or hospital caregiver’s failure to respond within the required</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
timelines regarding the final disposition of the arrest for a crime that would constitute a disqualifying conviction shall result in the applicant's, caregiver's or hospital caregiver's temporary disqualification from employment as a caregiver or hospital caregiver pending written documentation submitted to the department evidencing the final disposition of the arrest. Information submitted to the department may be evidence, for example, of the certified copy of an acquittal, dismissal or conviction of a lesser included crime. In instances where the applicant, caregiver or hospital caregiver has failed to respond within the required timelines the department shall provide notice by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A., of Section 7.1.9.9.

(3) The department will not make a final determination for an applicant, caregiver or hospital caregiver with a pending potentially disqualifying conviction for which no final disposition has been made. In instances of a pending potentially disqualifying conviction for which no final disposition has been made, the department shall notify the care provider, applicant, caregiver or hospital caregiver by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A, of Section 7.1.9.9.

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

A. homicide;

B. trafficking, or trafficking in controlled substances;

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

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

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

F. crimes involving child abuse or neglect;

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

H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.
Tag # 1A26
Consolidated On-line Registry
Employee Abuse Registry

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not maintain documentation in the employee’s personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 2 of 8 Agency Personnel.</td>
</tr>
</tbody>
</table>

The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:

Direct Support Personnel (DSP):

- #203 – Date of hire 10/14/2014.

The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:

Direct Support Personnel (DSP):


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

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

Provider:
employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

E. **Documentation for other staff.** With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual’s current licensure as a health care professional or current certification as a nurse aide.

F. **Consequences of noncompliance.** The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.
<table>
<thead>
<tr>
<th>Tag # 1A28.1 Incident Mgt. System - Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS</strong></td>
<td>Based on record review and interview, the Agency did not ensure Incident Management Training for 4 of 8 Agency Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</strong></td>
<td><strong>Direct Support Personnel (DSP):</strong></td>
<td><strong>Provider:</strong></td>
</tr>
<tr>
<td><strong>A. General:</strong> All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner.</td>
<td>- Incident Management Training (Abuse, Neglect and Exploitation) (DSP# 201, 202, 203, 204)</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td><strong>B. Training curriculum:</strong> Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider’s facility. Training shall be conducted in a language that is understood by the employee or volunteer.</td>
<td><strong>C. Incident management system training curriculum requirements:</strong></td>
<td></td>
</tr>
</tbody>
</table>
(1) The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to:
   (a) an overview of the potential risk of abuse, neglect, or exploitation;
   (b) informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form;
   (c) specific instructions of the employees’ legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths;
   (d) specific instructions on how to respond to abuse, neglect, or exploitation;
   (e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury.

(2) All current employees and volunteers shall receive training within 90 days of the effective date of this rule.

(3) All new employees and volunteers shall receive training prior to providing services to consumers.

D. Training documentation: All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be
made available immediately upon a division representative’s request. Failure to provide employee and volunteer training documentation shall subject the 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.
<table>
<thead>
<tr>
<th>Tag # 1A36</th>
<th>Service Coordination Requirements</th>
<th>Standard Level Deficiency</th>
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<tbody>
<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</td>
<td>Based on record review, the Agency did not ensure that Orientation and Training requirements were met for 1 of 2 Service Coordinators.</td>
<td></td>
</tr>
<tr>
<td>K. In addition to the applicable requirements described in policy statements B – I (above), direct support staff, direct support supervisors, and internal service coordinators shall complete DDSD-approved core curriculum training. Attachments A and B to this policy identify the specific competency requirements for the following levels of core curriculum training:</td>
<td>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</td>
<td></td>
</tr>
<tr>
<td>1. Introductory Level – must be completed within thirty (30) days of assignment to his/her position with the agency.</td>
<td>• Sexuality for People with Developmental Disabilities (SC #206)</td>
<td></td>
</tr>
<tr>
<td>2. Orientation – must be completed within ninety (90) days of assignment to his/her position with the agency.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>3. Level I – must be completed within one (1) year of assignment to his/her position with the agency.</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</table>

NMAC 7.26.5.7 “service coordinator”: the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency

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

(i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;
(ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;
(iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;
(iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;
**Service Domain: Health and Welfare** –  The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.

<table>
<thead>
<tr>
<th>Tag #1A08.2 Healthcare Requirements</th>
<th>Condition of Participation Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| **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. | After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 9 of 9 individuals receiving Community Inclusion and Living Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Community Inclusion Services / Other Services Healthcare Requirements (Individuals Receiving Inclusion / Other Services Only):**  
  - **Annual Physical** (#1, 2, 3, 4, 7, 8, 9)  
  - **Dental Exam**  
    - Individual #2 - 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 the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. | Provider: State your Plan of Correction for the deficiencies cited in this tag here: → |          |
Developemental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013

Chapter 5 (CIES) 3. Agency Requirements
H. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy.

Chapter 6 (CCS) 3. Agency Requirements:
G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

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

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

Chapter 12 (SL) 3. Agency Requirements:
D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are

- Individual #4 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.
- Individual #6 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.
- Individual #7 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.
- Individual #8 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.
- Individual #9 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.

- Vision Exam
  - Individual #2 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
  - Individual #3 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
  - Individual #4 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
  - Individual #5 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
required to comply with the DDSD Individual Case File Matrix policy.

**Chapter 13 (IMLS) 2. Service Requirements:**

C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items)…


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

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

**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

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<tbody>
<tr>
<td>○ Individual #6 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Individual #7 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Individual #8 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Individual #9 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</td>
<td></td>
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</tbody>
</table>
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, whichever 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 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
(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).
<table>
<thead>
<tr>
<th>Tag #</th>
<th>CQI System</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A03</td>
<td>CQI System</td>
<td>Based on record review, the Agency did not implement their Continuous Quality Management System as required by standard.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

**ARTICLE 17. PROGRAM EVALUATIONS**

d. PROVIDER shall have a Quality Management and Improvement Plan in accordance with the current MF Waiver Standards and/or the DD Waiver Standards specified by the DEPARTMENT. The Quality Management and Improvement Plan for DD Waiver Providers must describe how the PROVIDER will determine that each waiver assurance and requirement is met. The applicable assurances and requirements are: (1) level of care determination; (2) service plan; (3) qualified providers; (4) health and welfare; (5) administrative authority; and, (6) financial accountability. For each waiver assurance, this description must include:

1. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance;

   - The entities or individuals responsible for conducting the discovery/monitoring processes;

2. The types of information used to measure performance; and,

3. The frequency with which performance is measured.

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

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

- **Effectiveness and timeliness of implementation of ISPs, and associated support including trends in achievement of individual desired outcomes:** *(CIES only)*

- **Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes:** *(CCS, CIHS, IMLS only)*

- **Analysis of General Events Reports data in Therap;**

- **Compliance with Caregivers Criminal History Screening requirements;**

- **Compliance with Employee Abuse Registry requirements;**

**CHAPTER 5 (CIES) 3. Agency Requirements: J. Quality Assurance/Quality Improvement (QA/QI) Program:** Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.

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

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

   a. **Implementation of ISPs:** extent to which services are delivered in accordance with ISPs and associated support plans with WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as

   e. Compliance with DDSD training requirements;

   f. Patterns/Trends of reportable incidents;

   g. Results of improvement actions taken in previous quarters;

   h. Sufficiency of staff coverage;

   i. Action taken regarding individual grievances;

   j. Presence and completeness of required documentation;

   k. Significant program changes.

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

**NOTE:** The Continuous Quality Improvement Plan provided by the agency was only a formal feedback survey for clients and their guardians to fill out.
effectiveness of such implementation as indicated by achievement of outcomes;

3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:
   a. Analysis of General Events Reports data in Therap;
   b. Compliance with Caregivers Criminal History Screening requirements;
   c. Compliance with Employee Abuse Registry requirements;
   d. Compliance with DDSD training requirements;
   e. Patterns of reportable incidents;
   f. Results of improvement actions taken in previous quarters;
   g. Sufficiency of staff coverage;
   h. Effectiveness and timeliness of implementation of ISPs, and associated support including trends in achievement of individual desired outcomes;
   i. Results of General Events Reporting data analysis;
   j. Action taken regarding individual grievances;
   k. Presence and completeness of required documentation;
   l. A description of how data collected as part of the agency’s QA/QI Plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QA/QI process; and
   m. Significant program changes.
CHAPTER 6 (CCS) 3. Agency Requirements:
I. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities.

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

2. Implementing a QI Committee: The QA/QI committee shall convene at least quarterly and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting shall be documented. The QA/QI review should address at least the following:
   a. The extent to which services are delivered in accordance with ISPs, associated support plans and WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such
implementation as indicated by achievement of outcomes;

b. Analysis of General Events Reports data;
c. Compliance with Caregivers Criminal History Screening requirements;
d. Compliance with Employee Abuse Registry requirements;
e. Compliance with DDSD training requirements;
f. Patterns of reportable incidents; and
g. Results of improvement actions taken in previous quarters.

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

a. Sufficiency of staff coverage;
b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes;
c. Results of General Events Reporting data analysis;
d. Action taken regarding individual grievances;
e. Presence and completeness of required documentation;
f. A description of how data collected as part of the agency’s QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
g. Significant program changes.
CHAPTER 7 (CIHS) 3. Agency Requirements:

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

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

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

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

b. Analysis of General Events Reports data;

c. Compliance with Caregivers Criminal History Screening requirements;

d. Compliance with Employee Abuse Registry requirements;

e. Compliance with DDSD training requirements;

f. Patterns of reportable incidents; and

g. Results of improvement actions taken in previous quarters.

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

a. Sufficiency of staff coverage;

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

c. Results of General Events Reporting data analysis;

d. Action taken regarding individual grievances;
e. Presence and completeness of required documentation;

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

g. Significant program changes.

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

1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.
2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

a. The extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;

b. Analysis of General Events Reports data;

c. Compliance with Caregivers Criminal History Screening requirements;

d. Compliance with Employee Abuse Registry requirements;

e. Compliance with DDSD training requirements;

f. Patterns in reportable incidents; and

g. Results of improvement actions taken in previous quarters.

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

a. Sufficiency of staff coverage;

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

c. Results of General Events Reporting data analysis, Trends in category II significant events;
d. Patterns in medication errors;
e. Action taken regarding individual grievances;
f. Presence and completeness of required documentation;
g. A description of how data collected as part of the agency’s QI plan was used;
h. What quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
i. Significant program changes.

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

1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.
2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:
   a. Implementation of the ISP and the extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration, and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;
   b. Analysis of General Events Reports data;
   c. Compliance with Caregivers Criminal History Screening requirements;
   d. Compliance with Employee Abuse Registry requirements;
   e. Compliance with DDSD training requirements;
   f. Patterns in reportable incidents; and
   g. Results of improvement actions taken in previous quarters.

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

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

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

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

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

b. Trends in General Events as defined by DDSD;

c. Compliance with Caregivers Criminal History Screening Requirements;

d. Compliance with DDSD training requirements;

e. Trends in reportable incidents; and

f. Results of improvement actions taken in previous quarters.

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

a. Sufficiency of staff coverage;

b. Effectiveness and timeliness of implementation of ISPs and associated

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

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

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

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

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

**NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:**

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

1. Community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements;
2. Community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and
3. Community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.
<table>
<thead>
<tr>
<th>Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation</th>
<th>Condition of Participation Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service</td>
<td>After an analysis of the evidence it has determined there is a significant potential for a negative outcome to occur.</td>
<td></td>
</tr>
<tr>
<td>Standards effective 11/1/2012 revised 4/23/2013</td>
<td>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 4 of 9 individuals.</td>
<td></td>
</tr>
<tr>
<td>Chapter 5 (CIES) 3. Agency Requirements</td>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
</tr>
<tr>
<td>H. Consumer Records Policy: All Provider Agencies</td>
<td>- Electronic Comprehensive Health Assessment Tool (eCHAT) (#8)</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>must maintain at the administrative office a</td>
<td>- Medication Administration Assessment Tool (#8)</td>
<td></td>
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<tr>
<td>confidential case file for each individual. Provider</td>
<td>- Comprehensive Aspiration Risk Management Plan:</td>
<td></td>
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<tr>
<td>agency case files for individuals are required to</td>
<td>- Not Found (#8)</td>
<td></td>
</tr>
<tr>
<td>comply with the DDSD Consumer Records Policy.</td>
<td>- Aspiration Risk Screening Tool (#8)</td>
<td></td>
</tr>
<tr>
<td>Chapter 6 (CCS) 2. Service Requirements. E.</td>
<td>- Special Health Care Needs:</td>
<td></td>
</tr>
<tr>
<td>The agency nurse(s) for Customized Community</td>
<td>- Nutritional Plan</td>
<td></td>
</tr>
<tr>
<td>Supports providers must provide the following</td>
<td>- Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.</td>
<td></td>
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<tr>
<td>services: 1. Implementation of pertinent PCP orders</td>
<td></td>
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<td>2. Ongoing oversight and monitoring of the individual’s health status and medically related supports when receiving this service;</td>
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<tr>
<td>3. Agency Requirements: Consumer Records Policy:</td>
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<tr>
<td>All Provider Agencies shall maintain at the</td>
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<td>administrative office a confidential case file for</td>
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<td>each individual. Provider agency case files for</td>
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<tr>
<td>individuals are required to comply with the DDSD</td>
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<tr>
<td>Individual Case File Matrix policy.</td>
<td></td>
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<tr>
<td>Chapter 7 (CIHS) 3. Agency Requirements: E.</td>
<td></td>
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<tr>
<td>Consumer Records Policy: All Provider Agencies</td>
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<td>must maintain at the administrative office a</td>
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<td>confidential case file for each individual. Provider</td>
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<td>agency case files for individuals are required to</td>
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<tr>
<td>comply with the DDSD Individual Case File Matrix</td>
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<td>policy.</td>
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<tr>
<td>Chapter 11 (FL) 3. Agency Requirements: D.</td>
<td></td>
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<tr>
<td>Consumer Records Policy: All Family Living</td>
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<tr>
<td>Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</td>
<td></td>
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<tr>
<td>I. Health Care Requirements for Family Living: 5.</td>
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<tr>
<td>A nurse employed or contracted by the Family</td>
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Living Supports provider must complete the e-CHAT, the Aspiration Risk Screening Tool, (ARST), and the Medication Administration Assessment Tool (MAAT) and any other assessments deemed appropriate on at least an annual basis for each individual served, upon significant change of clinical condition and upon return from any hospitalizations. In addition, the MAAT must be updated for any significant change of medication regime, change of route that requires delivery by licensed or certified staff, or when an individual has completed training designed to improve their skills to support self-administration.

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

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

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

d. Other nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency,

- **Endocrine**
  - Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.

- **Status of Care**
  - Individual #5 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.

- **Medical Emergency Response Plans**
  - **Endocrine**
    - Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.

  - **Seizures**
    - Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

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

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

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

a. That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has a MERP developed by a licensed nurse or other appropriate professional according to the DDSD Medical Emergency Response Plan Policy, that DSP have been trained to implement such plan(s), and ensure that a copy of such plan(s) are readily available to DSP in the home;

b. That an average of five (5) hours of documented nutritional counseling is available annually, if recommended by the IDT and clinically indicated;

c. That the nurse has completed legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served, as well as all
interactions with other healthcare providers serving the individual. All interactions must be documented whether they occur by phone or in person; and

d. Document for each individual that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Chapter 1. III. E. (1 - 4)

(1) Documentation of nursing assessment activities
(2) Health related plans
(4) General Nursing Documentation


**CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS B. IDT Coordination**

(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.
<table>
<thead>
<tr>
<th>Tag # 1A27</th>
<th>Incident Mgt. Late and Failure to Report</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS</td>
<td>Based on the Incident Management Bureau's Late and Failure Reports, the Agency did not report suspected abuse, neglect, or exploitation, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 3 of 9 individuals.</td>
<td></td>
</tr>
<tr>
<td>NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
</tbody>
</table>

**A. Duty to report:**

(1) All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers.

(2) All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety.

**B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division’s hotline to report the incident.

**C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:**

(1) Abuse, neglect, and exploitation, suspicious injury or death reporting: Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division’s toll-free hotline number 1-800-445-6242. Any consumer,
family member, or legal guardian may call the division’s hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division’s abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division’s toll free hotline number, 1-800-445-6242.

(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers: In addition to calling the division’s hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division’s abuse, neglect, and exploitation or report of death form consistent with the requirements of the division’s abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division’s abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division’s website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct
knowledge of the incident participates in the preparation of the report form.
(3) **Limited provider investigation:** No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation.
(4) **Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall:
   (a) develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable;
   (b) be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division’s direction, if necessary; and
   (c) provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division’s website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057.
(5) **Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident.
(6) **Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the
consumer’s legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division’s investigatory representative.

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

**Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation.
<table>
<thead>
<tr>
<th>Tag # 1A28.2</th>
<th>Incident Mgt. System - Parent/Guardian Training</th>
<th>Condition of Participation Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.14.9INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</td>
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<tr>
<td>A. General: All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner.</td>
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<tr>
<td>E. Consumer and guardian orientation packet: Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.</td>
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<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</td>
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<td>Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 5 of 9 individuals.</td>
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<td>Review of the Agency individual case files revealed the following items were not found and/or incomplete:</td>
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<tr>
<td>• Parent/Guardian Incident Management Training (Abuse, Neglect and Exploitation) (#2, 3, 6, 7, 8)</td>
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<td>Provider:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
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<tr>
<td>Provider:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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### Tag # 1A29
**Complaints / Grievances**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Acknowledgement</th>
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<tbody>
<tr>
<td><strong>NMAC 7.26.3.6</strong></td>
<td>Based on record review, the Agency did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 4 of 9 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete:</td>
</tr>
<tr>
<td><strong>NMAC 7.26.3.13 Client Complaint Procedure Available.</strong> A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01]</td>
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<tr>
<td><strong>NMAC 7.26.4.13 Complaint Process: A. (2).</strong> The service provider’s complaint or grievance procedure shall provide, at a minimum, that: (a) the client is notified of the service provider’s complaint or grievance procedure</td>
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</tr>
<tr>
<td><strong>Provider:</strong></td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

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

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Survey Report #: Q.16.1.DDW.242907870.2.RTN.01.15.266
**Service Domain: Medicaid Billing/Reimbursement** – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

<table>
<thead>
<tr>
<th>Tag # IS30</th>
<th>Customized Community Supports Reimbursement</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 3 of 4 individuals.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
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<td>Individual #4 June 2015</td>
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<tr>
<td></td>
<td></td>
<td>a. The Agency billed 156 units of Customized Community Supports (group) (T2021 HB UA) from 6/17/2015 through 6/24/2015. Documentation received accounted for 152 units.</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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<td></td>
<td></td>
<td>b. The Agency billed 216 units of Customized Community Supports (group) (T2021 HB UA) from 6/25/2015 through 7/7/2015. Documentation received accounted for 190 units.</td>
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<td>Individual # 6 July 2015</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>a. The Agency billed 54 units of Customized Community Supports (group) (T2021 HB U5) on 7/7/2015. Documentation received accounted for 23 units.</td>
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<td></td>
<td>b. The Agency billed 117 units of Customized Community Supports (group) (T2021 HB U5) from 7/8/2015 through 7/14/2015. Documentation received accounted for 98 units</td>
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</tbody>
</table>


Survey Report #: Q.16.1.DDW.242907870.2.RTN.01.15.266
1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit.

2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit.

3. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group.

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

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

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

C. Billable Activities:
1. All DSP activities that are:
   a. Provided face to face with the individual;
   b. Described in the individual’s approved ISP;
   c. Provided in accordance with the Scope of Services; and

   Individual #8
   June 2015
   - The Agency billed 82 units of Customized Community Supports (individual) (H2021 HB U1) from 5/20/2015 to 6/9/2015. Documentation received accounted for 76 units.
   - The Agency billed 58 units of Customized Community Supports (individual) (H2021 HB U1) from 6/10/2015 to 6/23/2015. Documentation received accounted for 36 units.

   July 2015
   - The Agency billed 20 units of Customized Community Supports (individual) (H2021 HB U1) from 7/8/2015 to 7/14/2015. No documentation was found for 07/08/2015 through 07/14/2015 to justify the 20 units billed.
   - The Agency billed 40 units of Customized Community Supports (individual) (H2021 HB U1) from 7/15/2015 to 7/21/2015. Documentation received accounted for 20 units
<p>| | |</p>
<table>
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<tbody>
<tr>
<td><strong>d.</strong> Activities included in billable services, activities or situations.</td>
<td></td>
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<tr>
<td><strong>2.</strong> Purchase of tuition, fees, and/or related materials associated with adult education opportunities as related to the ISP Action Plan and Outcomes, not to exceed $550 including administrative processing fee.</td>
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<tr>
<td><strong>3.</strong> Customized Community Supports can be included in ISP and budget with any other services.</td>
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</tbody>
</table>

**MAD-MR: 03-59 Eff 1/1/2004**

**8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:**

Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.
Date: January 26, 2016  

To: Manish Gaur  
Provider: People Center Services, LLC  
Address: 1807 2nd Street, Unit 82  
State/Zip: Santa Fe, New Mexico, 87505  

E-mail Address: manishgaur@netzero.com  
Region: Northeast  
Survey Date: August 24 – 28, 2015  
Program Surveyed: Developmental Disabilities Waiver  

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

Survey Type: Routine  

Dear Mr. Gaur;  

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 of 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,  

*Amanda Castañeda*  
Amanda Castañeda  
Plan of Correction Coordinator  
Quality Management Bureau/DHI  

**Q.16.1.DDW.242907870.2.RTN.09.16.26**