Date: April 29, 2010

To: David Sorensen, Executive Director
Provider: Southwest Services for the Deaf, Inc.
Address: 3301 R. Coors Rd. NW Ste. 265
State/Zip: Albuquerque, New Mexico 87120

E-mail Address: southwestdeafservices.com
asi@nm.net

Region: Metro
Survey Date: April 6 - 9, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Inclusion (Adult Habilitation & Community Access)
Survey Type: Initial
Team Leader: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Selma Dodson, Community Inclusion Coordinator, Developmental Disabilities Supports Division

Dear Mr. Sorensen,

The Division of Health Improvement/Quality Management Bureau has completed a quality review 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.

Quality Management Approval Rating:
The Division of Health Improvement is pleased to issue your new agency a "PROVISIONAL" rating for compliance with DDSD Standards and regulations. As part of your Provisional rating, QMB will conduct an additional annual review prior to the end of your current provider agreement. The outcome of that review will be used in determining future DHI ratings.

Plan of Correction:
The attached Report of Findings identifies deficiencies found during your agency's survey. You are required to complete and implement a Plan of Correction (POC). Please submit your agency's Plan of Correction (POC) in the space on the two right columns of the Report of Findings. See attachment A for additional guidance in completing the POC. The response is due to the parties below within 10 working days of the receipt of this letter:

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

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

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 working days. If your plan of correction is denied, you must resubmit a revised plan ASAP for approval. All remedies must still be completed within 45 working days of the original submission.

Failure to submit, complete or implement your POC within the required time frames will result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Request for Informal Reconsideration of Findings (IRF):
If you disagree with a determination of noncompliance (finding) you have 10 working 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

A request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 working days. Providers may not appeal the nature or interpretation of the standard or regulation, the team composition, sampling methodology or the Scope and Severity of the finding.

If the IRF approves the change or removal of a finding, you will be advised of any changes.

This IRF process is separate and apart from the Informal Dispute Resolution (IDR) and Fair Hearing Process for Sanctions from DOH.

Please call the Team Leader at 505-231-7436, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Tony Fragua, BFA

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

Survey Process Employed:

Entrance Conference Date:	April 6, 2010
Present:	**Southwest Services for the Deaf, Inc.** David Sorensen, Executive Director Steve Henning, Direct Care Support/Service Coordinator **DOH/DHI/QMB** Tony Fragua, BFA, Team Lead/Healthcare Surveyor **DDSD - Metro Regional Office** Selma Dodson, Community Inclusion Coordinator
Exit Conference Date:	April 9, 2010
Present:	**Southwest Services for the Deaf, Inc.** David Sorensen, Executive Director Steve Henning, Direct Care Support/Service Coordinator **DOH/DHI/QMB** Tony Fragua, BFA, Team Lead/Healthcare Surveyor **DDSD - Metro Regional Office** Selma Dodson, Community Inclusion Coordinator
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 3 1 - Jackson Class Members 2 - Non-Jackson Class Members 3 - Adult Habilitation 3 - Community Access
Persons Served Interviewed	Number: 2
Persons Served Observed	Number: 1 (One individual was not available during survey)
Records Reviewed (Persons Served)	Number: 3
Administrative Files Reviewed	• Billing Records • Medical Records • Incident Management Records • Personnel Files • Training Records • Agency Policy and Procedure • Caregiver Criminal History Screening Records • Employee Abuse Registry • Human Rights Notes and/or Meeting Minutes • Nursing personnel files • Evacuation Drills • Quality Improvement/Quality Assurance Plan

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

Attachment A

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8647.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency ("Responsible Party"), and by WHEN ("Date Due").
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency's Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-222-8661), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been "Approved" or "Denied".
- Whether your POC is "Approved" or "Denied", you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is "Denied" it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- The following Deficiencies must be corrected within the deadlines below (after receipt of your Survey Report):

    - CCHS and EAR: 10 working days
    - Medication errors: 10 working days
    - IMS system/training: 20 working days
    - ISP related documentation: 30 working days
    - DDSD Training 45 working days

- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8647 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Attachment B

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

Key to Scope scale:
Isolated:
A deficiency that is limited to 1% to 15% of the sample, usually impacting no more than one or two individuals in the sample.

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

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

Key to Severity scale:
Low Impact Severity: (Blue)
Low level findings have no or minimal potential for harm to an individual. Providers that have no findings above a "C" level may receive a "Quality" Certification approval rating from QMB.

Medium Impact Severity: (Tan)
Medium level findings have a potential for harm to an individual. Providers that have no findings above a "F" level and/or no more than two F level findings and no F level Conditions of Participation may receive a "Merit" Certification approval rating from QMB.

High Impact Severity: (Green or Yellow)
High level findings are when harm to an individual has occurred. Providers that have no findings above "I" level may only receive a "Standard" Approval rating from QMB and will be referred to the IRC.

High Impact Severity: (Yellow)
"J, K, and L" Level findings:
This is a finding of Immediate Jeopardy. If a provider is found to have "I" level findings or higher, with an outcome of Immediate Jeopardy, including repeat findings or Conditions of Participation they will be referred to the Internal Review Committee.

The QMB Approval Rating

The QMB approval rating is the provider incentive to encourage quality service and correlates the review outcome with the QMB review frequency and its recommendation to DDSD to determine the length of the provider agreement. The "Approval rating" is based on the Scope and Severity of the review findings. There are five levels of "Approval" that a provider may receive. They are:

"Quality" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Quality" Rating. To qualify for a QMB "Quality" rating of approval" and a three (3) year QMB review cycle and provider agreement recommendation, the provider must not have any findings that are a condition of participation and no findings of "F" level or higher on the Scope and Severity Matrix with no more that three (3) D or E level findings.

"Merit" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Merit" Rating. To qualify for a QMB "Merit" rating of approval" and a two (2) year QMB review cycle and provider agreement recommendation, the provider must not have more than three (3) findings that are a condition of participation and no more than three (3) "F" level findings with no findings of a "G" level or higher on the Scope and Severity Matrix and no more that six (6) D or E level findings.

"Standard" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Standard" Rating. To qualify for a QMB "Standard" rating of approval" and a one (1) year QMB review cycle and provider agreement recommendation, the provider must not have more than six (6) findings that are a condition of participation and no more than six (6) "F" level findings with no findings of a "G" level or higher on the Scope and Severity Matrix and no more that six (6) D or E level findings.

"Sub-Standard" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider has "Sub-standard" performance. To qualify for a QMB "Sub-Standard" rating of approval" and a three to six month QMB review cycle, with a referral to the Internal Review Committee and provider agreement recommendation, the provider may have any of the following findings:

- seven (7) or more findings that are a condition of participation
- seven (7) or more "F" level findings
- any findings of a "G" level or higher
- nine (9) or more D or E level findings

A referral to the IRC is required for any "Sub-standard" rating. Depending upon the egregious nature of the findings the IRC shall take appropriate sanction actions up to and including contract termination.

"Provisional" Approval Rating:
New DD service providers may qualify for a QMB "Provisional" Approval Rating upon successfully completing their initial QMB Quality Survey.
The QMB DD Manager will review the Report of Findings and determine if the provider has achieved at least a standard rating of approval. If successful, the provider may receive a one (1) year contract extension. QMB will notify the DDSD Contract unit of the "Provisional" approval rating.

Attachment C

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

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

To informally dispute a finding the provider must request in writing an Informal Reconsideration of the Finding (IRF) to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.

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) and must specify in detail the request for reconsideration and why the finding is inaccurate. The **IRF request must include all supporting documentation or evidence that was not previously reviewed during the survey process.**

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received in 10 days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed 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 Scope and Severity of a finding.
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition
- Providers may not request an IRF to challenge the QMB Quality Approval Rating and the length of their DDSD provider contract.

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is successfully reconsidered, it will be noted and will be removed or modified from the report. 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.

Administrative Review Process:
If a Provider desires to challenge the decision of the IRF committee they may request an Administrative Review by the DHI and DDSD Director. The Request must be made in writing to the QMB Bureau Chief and received within 5 days of notification from the IRF decision.

Regarding IRC Sanctions:
The Informal Reconsideration of the Finding process is a separate process specific to QMB Survey Findings and should not be confused with any process associated with IRC Sanctions.

If a Provider desires to Dispute or Appeal an IRC Sanction that is a separate and different process. Providers may choose the Informal Dispute Resolution Process or the Formal Medicaid Fair Hearing Process to dispute or appeal IRC sanctions, please refer to the DOH Sanction policy and section 39 of the provider contract agreement.

Agency: **Southwest Services for the Deaf, Inc. - Metro Region**
Program: Developmental Disabilities Waiver
Service: Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Initial Survey
Date of Survey: **April 6 - 9, 2010**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A03 CQI System	**Scope and Severity Rating: C**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both	Review of the Agency's Continuous Quality Improvement Plan provided during the on-site survey did not contain the general components required by Standards, additionally the Agency failed to establish and implement a quality improvement system for reviewing alleged complaints and incidents. **The Agency's CQI Plan did not contain the following components:** (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation; Additionally a review of the Agency's Quality Improvement regarding incident management did not contain the following: (4) community based service providers providing		

supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:** **E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system: **(1)** community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements; **(2)** community based service providers providing developmental disabilities services must have a designated incident management coordinator in place; **(4)** community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.	developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues. When #41 was asked if the Agency had an Incident Management Quality Improvement System, which included, a process for reviewing alleged, complaints & incident; documentation of internal investigations of alleged violations; reasonable steps taken to prevent further incident and documentation of corrective active, the following was reported: • #41, stated, "We don't have any incidents internal or external to track. I would feel reluctant to investigate external to state reports, I feel DOH/DHI would do a better job, their the professionals, feel I would not support the clients well, this way, by asking them so many questions, that it could confuse them."		

Tag # 1A05 (CoP) General Requirements	Scope and Severity Rating: F		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1** II**. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **A. General Requirements:** (2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.	Based on record review, the Agency failed to review and update its written policies and procedures every three years or as needed. The following polices and procedures provided during the on-site survey (April 6 - 9, 2010) showed no evidence of being reviewed every three years or being updated as needed: • Southwest Services for the Deaf: Polices and Procedure Manual; Last reviewed and/or revised date 2/1/2005. ° "Abuse or Neglect by Staff" – page 2. ° "Access Authorization" - page 4. ° "Access Establishment" – page 7. ° "Access Modification" – page 10. ° "Accounting of Disclosures" – page 13. ° "Adequate Staff Coverage" – page 15. ° "Admission" – page 16. ° "Behavior Management" – page 21. ° "Business Associates" – page 24. ° "Client Absent without Authorization" – page 26. ° "Client Funds" – page 27. ° "Client Information" – page 28. ° "Client Possessions" – page 31. ° "Client refusal of treatment/medications" – page 32 ° "Client Rights" – page 33. ° "Confidentiality" – page 34. ° "Consent to Treat for Individuals Who Are Not Their Own Guardians" – page 37. ° "Continue Care/Termination Planning" – page 38. ° "Corrective Counseling Protocol" – page 40. ° "Criminal Records Check and Clearance' – page 42. ° "Cultural Competency" – page 44. ° "Data Access Policy" – page 45-48.		

	° "Death of a Client" – page 49. ° "Disaster Plan" – page 50. ° "Disclosure of Client Information' – page 52. ° "Disclosure of Personnel Information' – page 59. ° "Documentation" – page 60. ° "Drug Policy" – page 61. ° "Email Policy" – page 66. ° "Emergency Access to PHI" – page 69. ° "Emergency Authorization to Disclose Client Information" – page 70. ° "Emergency Termination of Services" – page 72. ° "Employment Termination" – page 73. ° "Facsimile Policy (FAX)" – page 74. ° "Fire Evacuation Procedure" – page 77. ° "Fire Safety Training" – page 78. ° "Free Time" – page 79. ° "Grievance Procedure for Employees" – page 80. ° "Grievance Procedures for Individuals Receiving Services" – page 81. ° "Healthcare" – page 83. ° "Healthcare Record Amendment" – page 84. ° "HIPAA Records Retention" – page 86. ° "Hiring Procedures" – page 87. ° "Incident Reports" – page 91. ° "Infection Control/Bloodborne Pathogens" – page 94. ° "Internal Audits" – page 99. ° "Internet Security" – page 100. ° "Law Enforcement Intervention" – page 102. ° ‘‘Maintenance of Building and Equipment" – page 104. ° "Media Control" – page 105. ° "Medical Assistance" – page 106. ° "Medication Administration" – page 107. ° "Medical Emergency" – page 108. ° Cardiac/Respiratory Arrest ° Care of Choking Victim		

	° First Aid Treatment ° "Medical Records Inspection and Copying" – page 113. ° "Minimum Necessary Protocol" – page 114. ° "Network Restoration" – page 115. ° "Notice of Privacy Practice" – page 116. ° "Passwords" – page 117. ° "Personnel" –page 118. ° "Personnel File Destruction" – page 119. ° "Personnel Record" – page 120. ° "Policies and Procedures" – page 122. ° "Processing Records (Client)" – page 123. ° "Processing Records (Personnel) – page 124. ° "Psychiatric Emergency" – page 125. ° "Record Retention" – page 128. ° "Release of Information Forms" – page 129. ° "Reporting Suspected Abuse, Neglect, and Exploitation" – page 131. ° "Restrictions of Protected Health Information" – page 134. ° "Retention Strategy" – page 135. ° "Safety Policy – Motor Vehicles" – page 136. ° "Safety Procedures" – page 137. ° "Search Procedure" – page 138. ° "Sexual Acting Out" – page 140. ° "Smoking" – page 141. ° "Software and Hardware" – page 142. ° "Software Maintenance" – page 144. ° "Staff Training" – page 145. ° "Storage of Client Records" – page 147. ° "Storage of Personnel Records" – page 148. ° "Suicide Protocol" – page 149. ° "Use or Depiction of Individuals" – page 150. ° "Visitor Access" – page 151.		

Tag # 1A06 Provider Agency Policy and Procedure Requirements	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **B. Provider Agency Policy and Procedure Requirements:** All Provider Agencies, in addition to requirements under each specific service standard shall at a minimum develop, implement and maintain, at the designated Provider Agency main office, documentation of policies and procedures for the following: (1) Coordination of Provider Agency staff serving individuals within the program which delineates the specific roles of agency staff, including expectations for coordination with interdisciplinary team members who do not work for the provider agency; (2) Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated; and (3) Agency protocols for disaster planning and emergency preparedness.	Based on record review, the Agency failed to implement and maintain, at the Agency main office, documentation of policies and procedures for the following: (3) Agency protocols for disaster planning and emergency preparedness.		

Tag # 1A08 Agency Case File	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **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	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 3 of 3individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • **Current Emergency & Personal Identification Information** ° Did not contain Pharmacy Information (#1) ° Did not contain Physician Information (#1) • **Annual ISP** ° Not Current (#3) • ISP Signature Page (#3) • Individual Specific Training Section (ISP) (#3) • **Annual Physical** (#2 & 3) • **Dental Exam** ° Individual #1 - As indicated by the Individual's ISP Assessment Tracking Sheet (Routine annual/6 month cleaning) & DDSD file matrix Dental Exams are to be conducted annually. Exam was to be completed 1/13/2010. No evidence of exam was found. ° 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. • **Vision Exam** ° Individual #2 - As indicated by the DDSD file		

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.	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. • **Cholesterol, Blood Glucose & Bloods Levels** ° Individual #2 - As indicated by the documentation reviewed, lab work was ordered on 3/4/2009. Follow-up was to be completed in 1 year. No evidence of follow-up found.		

Tag # 1A11 (CoP) Transportation P&P	Scope and Severity Rating: F		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **G. Transportation:** Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and procedures must address at least the following topics: (1) Drivers' requirements, (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (3) Vehicle maintenance and safety inspections, (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures, (5) Emergency Plans, including vehicle evacuation techniques, (6) Documentation, and (7) Accident Procedures**.** **Department of Health (DOH)** **Developmental Disabilities Supports Division (DDSD) Policy** Training Requirements for Direct Service Agency	Based on record review, the Agency failed to have a written policies and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals. Review of Agency's policies and procedures indicated the following elements were not found: (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (3) Vehicle maintenance and safety inspections, (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures, (5) Emergency Plans, including vehicle evacuation techniques, (6) Documentation, and (7) Accident Procedures		

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)			

Tag # 1A12 Reimbursement/Billable Units	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed, which contained the required information for 3 of 3 individuals. Individual #1 December 2009 • The Agency billed 100 units of Adult Habilitation from 12/1/2009 through 12/30/2009. Documentation did not contain a signature/authenticated name of the staff providing the service on 12/1, 3, 8, 15, 22 & 30 to justify billing. January 2010 • The Agency billed 108 units of Adult Habilitation from 1/05/2010 through 1/26/2010. Documentation did not contain a signature/authenticated name of the staff providing the service on 1/5, 14, 19, 21 & 26 to justify billing. February 2010 • The Agency billed 18 units of Community Access on 2/04/2010. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. Individual #2 December 2009 • The Agency billed 184 units of Adult Habilitation from 12/04/2009 through 12/30/2009. Documentation did not contain a signature/authenticated name of the staff providing the service on 12/4, 7, 9, 11, 16, 18, 28 & 30 to justify billing. January 2010 • The Agency billed 144 units of Adult Habilitation from 1/06/2010 through 1/29/2010. Documentation did not contain a		

	signature/authenticated name of the staff providing the service on 1/6, 8, 15, 22 & 29 to justify billing. February 2010 • The Agency billed 84 units of Community Access on 2/02/2010 through 2/24/2010. Documentation did not contain a signature/authenticated name of the staff providing the service on 2/2, 15, 17 & 24 to justify billing. Individual #3 December 2009 • The Agency billed 308 units of Adult Habilitation from 12/1/2009 through 12/30/2009. Documentation did not contain a signature/authenticated name of the staff providing the service on 12/1, 2, 3, 7, 8, 9, 10, 15, 16, 22 & 23 to justify billing. • The Agency billed 60 units of Community Access on 12/08/2009 through 12/23/2009. Documentation did not contain a signature/authenticated name of the staff providing the service on 12/8, 17 & 23 to justify billing. January 2010 • The Agency billed 144 units of Adult Habilitation from 1/04/2010 through 1/26/2010. Documentation did not contain a signature/authenticated name of the staff providing the service on 1/5, 6, 7, 19, 20, 21 & 26 to justify billing. • The Agency billed 90 units of Community Access on 1/11/2010 through 1/28/2010. Documentation did not contain a signature/authenticated name of the staff providing the service on 1/11, 13, 25 & 28 to justify billing.		

	February 2010 • The Agency billed 84 units of Adult Habilitation from 2/16/2010 through 2/22/2010. Documentation did not contain a signature/authenticated name of the staff providing the service on 2/16, 17 & 22 to justify billing. • The Agency billed 204 units of Community Access on 2/1/2010 through 2/24/2010. Documentation did not contain a signature/authenticated name of the staff providing the service on 2/1, 2, 4, 8, 10, 11, 15, 17 & 24 to justify billing.		

Tag # 1A15 Healthcare Documentation - Nurse Contract/Employee	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6 VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **K. Nursing Requirements and Roles** (1) All Community Living Service Provider Agencies are required to have a registered nurse (RN) on staff. The agency nurse may be an employee or a sub-contractor. (3) A Community Living Support Provider Agency shall not use a licensed practical nurse (LPN) without a registered nurse (RN) supervisor.	Based on record review and interview, the Agency failed to provide an employed or contracted licensed registered nurse. Review of Agency records found no evidence of an employed or contracted nurse. When #41 was asked if the Agency had an employed or contracted licensed registered nurse, the following was reported: • #41 stated, "We don't currently have a nurse on contract but, I am working on making those arrangements, we rely on Residential nurses to give us their plans."		

Tag # 1A15 Nurse Availability	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **NEW MEXICO NURSING PRACTICE ACT CHAPTER 61, ARTICLE 3** I. "licensed practical nursing" means the practice of a directed scope of nursing requiring basic knowledge of the biological, physical, social and behavioral sciences and nursing procedures, which practice is at the direction of a registered nurse, physician or dentist licensed to practice in this state. This practice includes but is not limited to: (1) contributing to the assessment of the health status of individuals, families and communities; (2) participating in the development and modification of the plan of care; (3) implementing appropriate aspects of the plan of care commensurate with education and verified competence; (4) collaborating with other health care professionals in the management of health care; and (5) participating in the evaluation of responses to interventions;	Based on interview, the Agency failed to ensure nursing services were available as needed for 3 of 3 individuals. When DSP were asked about the availability of their agency nurse, the following was reported: • DSP #40 stated, "I don't know, ask my boss, the house (Residential) has a nurse."		

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities** (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the	Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 3 individual The following were not found, incomplete and/or not current: • Health Assessment Tool (#2 & 3) • Medication Administration Assessment Tool (#2 & 3) • **Quarterly Nursing Review of HCP/Crisis Plans:** ° None found for 12/2009 - 2/2010 (#2) ° None found for 4/2009 - 4/2010 (#3)		

caregiver upon request. (c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. (d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **(2) Health related plans** (a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.			

(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. (c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. (d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings. (3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended): (a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition. (b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal. (c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.			

(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions. (e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings. (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization. (g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author. (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed. **(4) General Nursing Documentation** (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person. (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.			

Tag # 1A22 Staff Competence	Scope and Severity Rating: F		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **F. Qualifications for Direct Service Personnel:** The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy	Based on interview, the Agency failed to ensure that training competencies were met for 1 of 1 Direct Service Personnel. **When DSP were asked if they received training on the Individual's ISP and what the plan covered, the following was reported:** • DSP #40 stated, "No." (Individual #2) **When DSP were asked if they received training on the Individual's Speech Therapy Plan and what the plan covered, the following was reported:** • DSP #40 stated, "No." According to the Individual Specific Training Section of the ISP, Individual requires a Speech Therapy Plan. (Individual #1) **When DSP were asked if they received training on the Individual's Health Care Plans and what the plan covered, the following was reported:** • DSP #40 stated, "I'm aware of his conditions but not trained on his plans, I know him." According to ISP the individual has a HAT score of 4 and the Individual Specific Training section of the ISP indicates there are HCPs for: Pain Management, Prevention of Skin Breakdown, Hypertension & High Risk for Falls. (Individual #2) **When DSP were asked if they had received training regarding the individual's Seizure Disorder, the following was reported:** • DSP #40 stated, "No one." According to the ISP, the individual has a diagnosis of Seizures. (Individual #2) **When DSP were asked if there was a person –**		

Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support. (6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows: (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes. **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:** A. Individuals shall receive services from competent and qualified staff.	**specific seizure plan/crisis plan, the following was reported:** • DSP #40 stated, "I don't remember seeing one." According to the ISP, the individual has a person-specific seizure crisis plan for Seizures. (Individual #2)		

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: F		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:** **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **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.	Based on record review, the Agency failed to 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 1 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** • #40 – Date of hire 10/08/2008		

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: F		
NMAC 7.1.12.8 **REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 1 of 1 Agency Personnel. **The following Agency personnel records contained NO evidence of the Employee Abuse Registry being completed:** • #40 – Date of hire 10/08/2008		

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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements.** **D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.			

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: F		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007** **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.	Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 1 of 1 Agency Personnel. • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#40) When #41 was asked if the Agency had established policies and procedures regarding incident management and incident management training, the following was reported: • #41 stated, “There is a policy in place but we haven’t been following the training requirement.”		

Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: F		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **E. Consumer and Guardian Orientation Packet:** Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 3 of 3 individuals. • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#1, 2 & 3)		

Tag # 1A28 (CoP) Incident Mgt. System - Posters	Scope & Severity Rating: F		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **F. Posting of Incident Management Information Poster:** All licensed health care facilities and community based service providers shall post two (2) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. All licensed health care facilities and community based service providers operating sixty (60) or more beds shall post three (3) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. The posters shall be posted where employees report each day and from which the employees operate to carry out their activities. Each licensed health care facility or community based service provider shall take steps to insure that the notices are not altered, defaced, removed, or covered by other material. [7.1.13.10 NMAC - N, 02/28/06]	Based on observation, the Agency failed to post two (2) or more Incident Management Information posters in a prominent public location for the following locations for 1 of 1 Administrative Location: The following locations were identified: Administrative Location: • 2202 Menaul Blvd. NE, Suite A Albuquerque, New Mexico 87107		

Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: C		
NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** 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] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** 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	Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 3 of 3 individuals. • Grievance/Complaint Procedure Acknowledgement (#1, 2 & 3)		

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: D		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division** **Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003** **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service provider agencies. The purpose of these	Based on record review and interview, the Agency failed to ensure the rights of Individuals was not restricted or limited for 1 of 3 Individuals. A review of Agency Individual files indicated 1 of 1 Individuals required Human Rights Committee Approval for restrictions. No documentation was found regarding Human Rights Approval for the following: • Physical Restraint - "Use restraint as a last resort…" Per Positive Behavioral Support Crisis Plan (Individual #3) When #41 was asked if the Agency had documentation of Human Rights approval, the following was reported: • #41 stated, "I would normally participate with Residential HRC for approval on my plans, I don't know why we didn't have one for (Individual #3)."		

committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans. Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies: • Aversive Intervention Prohibitions • Psychotropic Medications Use • Behavioral Support Service Provision. A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up. **A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS** Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval. 2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly. 3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** **B. 1. e.** If the PRN medication is to be used in			

response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).			

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: F		
NMAC 7.26.5.16.C and D **Development of the ISP. Implementation of the ISP.** The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 3 of 3 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • None found for 12/2009 - 2/2010 Individual #2 • None found for 12/2009 - 2/2010 Individual #3 • None found for 12/2009 - 2/2010 **Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • None found for 12/2009 - 2/2010 Individual #2 • None found for 12/2009 - 2/2010 Individual #3 • None found for 12/2009 - 2/2010		

Tag # 5I03 Employment First	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 III. COMMUNITY INCLUSION SERVICES REQUIREMENTS** **A. Implementation of the Employment First Principle for Adult Individuals** (1) When considering Community Inclusion Services (Supported Employment, Community Access, and Adult Habilitation), the IDT members are required to offer employment as a priority service over other day service options for all working age adults. In cases when employment is not the immediate goal, the IDT members shall document the reasons for this decision and develop strategies that will be undertaken to explore alternative options that may lead to employment (e.g., volunteer activities, career exploration, situational assessments, etc.). It is the responsibility of the IDT members and Case Manager to ensure that these decisions are based on informed choice. (2) Informed Choice of the Individual: In the context of employment, informed choice shall include the following: (a) Assessment of the individual's vocational interests, abilities and needs; (b) Information regarding the range of employment options available to the individual; (c) Information regarding self-employment and customized employment options and resources; (d) The opportunity for job exploration activities including volunteer work and/or trial work opportunities; and (e) Discussion of potential impact on the individual's benefits and services. (3) Compensation: When individuals receive compensation in Community Inclusion Services settings, the compensation shall comply with the Fair Labor Standards Act and Code of Federal Regulations. Medicaid funds (e.g., the Provider Agency's reimbursement) may not be used to pay the individual for work.	Based on interview and record review, the Agency was unable to explain what their responsibilities are regarding the Employment First Principal or show documentation of how this is implemented. Review of Agency files found no documented evidence of how the Employment 1st Principal is implemented. When #41 was asked how does the Agency ensures the implementation of the employment first principle for the individuals they serve and how this is documented, the following was reported: • #41 stated, "I don't have one on hand."		

Tag # 5I04 Meaningful Day	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 III. COMMUNITY INCLUSION SERVICES REQUIREMENTS** **B. Implementation of a Meaningful Day** (1) In the context of DD Waiver services, the term "meaningful day" means that services and supports provide individualized access for individuals with developmental disabilities to participate in activities and functions of community life that are desired and chosen by the general population. The term "day" does not exclusively denote activities that happen between 9:00 a.m. to 5:00 p.m. on weekdays. This includes purposeful and meaningful work, substantial and sustained opportunity for optimal health, self empowerment and personalized relationships, skill development and/or maintenance, and social, educational and community inclusion activities that are directly linked to the vision, goals and desired personal outcomes as stated in the individual's Individual Service Plan and as documented in daily schedules and progress notes.	Based on interview and record review, the Agency was unable to explain what their responsibilities are regarding Meaningful Day or show documentation of how this is implemented. Review of Agency files found no documented evidence of how Meaningful Day is determined. When #41 was asked how does the Agency ensure the implementation of meaningful day for the individuals they serve and how this is documented, the following was reported: • #41 stated, "I don't have one on hand."		

Tag # 5I09 - IDT Coordination	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **B. IDT Coordination** (1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and (2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.	Based on record review, the Agency failed to ensure 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 for 3 of 3 receiving Community Inclusion Services. The following documents were not found, incomplete and /or not current: • **Special Health Care Needs:** • Nutritional Plan ° Individual #1 - As indicated by the ISP Assessment Tracking Sheet of ISP the individual is required to have a plan. • **Health Care Plans** • Pain Management ° Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Prevention of Skin Bacteria ° Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Hypertension ° Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • High Risk for Falls ° Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Chronic Pain ° Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. • Use of Psychotropic Medication ° Individual #3 - As indicated by the IST section		

	of ISP the individual is required to have a plan. • **Crisis Plans** • Aspiration ° Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Cardiac Condition ° Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Medical Crisis Plan – GERD – Barrett Syndrome ° Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Gastrointestinal ° Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • ASL Interpreter ° Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Seizures ° Individual #3 - According to Positive Behavioral Support Plan the individual is diagnosed with seizures and is required to have a plan.		

Tag # 5I11 Reporting Requirements (CI Quarterly Report Components)	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **E. Provider Agency Reporting Requirements:** All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD.	Based on record review, the Agency failed to complete written quarterly status reports in compliance with standards for 3 of 3 individuals receiving Community Inclusion Services. Review of quarterly reports found the following components were not addressed, as required: **Individual #1** - The following were not found in the Adult Habilitation/Community Access Quarterly Report for 6/2009 - 12/2009: 1) Timely completion of relevant activities from ISP Action Plans 2) Progress towards desired outcomes in the ISP accomplished during the quarter; 3) Significant changes in routine or staffing; 4) Unusual or significant life events; 6) Data reports as determined by IDT members. 7) Identification and implementation of a meaningful day definition for each person served; 8) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. 10) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP **Individual #2** - The following were not found in the Adult Habilitation/Community Access Quarterly		

	Report for 6/2009 - 12/2009: 1) Timely completion of relevant activities from ISP Action Plans 2) Progress towards desired outcomes in the ISP accomplished during the quarter; 3) Significant changes in routine or staffing; 4) Unusual or significant life events; 6) Data reports as determined by IDT members. 7) Identification and implementation of a meaningful day definition for each person served; 8) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. 10) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP **Individual #3** - The following were not found in the Adult Habilitation/Community Access Quarterly Report for 6/2009 - 12/2009: 1) Timely completion of relevant activities from ISP Action Plans 2) Progress towards desired outcomes in the ISP accomplished during the quarter; 3) Significant changes in routine or staffing; 4) Unusual or significant life events; 6) Data reports as determined by IDT members.		

	7) Identification and implementation of a meaningful day definition for each person served; 8) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. 10) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP		

Tag # 5I36 CA Reimbursement	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS** **G. Reimbursement** (1) Billable Unit**:** A billable unit is defined as one-quarter hour of service. (2) Billable Activities**:** The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan; (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and (c) Non face-to-face hours do not exceed 10% of the monthly billable hours. (3) Non-Billable Activities**:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include: (a) Time and expense for training service personnel; (b) Supervision of agency staff; (c) Service documentation and billing activities; or (d) Time the individual spends in segregated facility-based settings activities.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 3 of 3 individuals. Individual #1 December 2009 • The Agency billed 54 units of Community Access on 12/08/2009 through12/28/2009. No documentation found to justify billing. January 2010 • The Agency billed a total of 48 units of Community Access on 1/07/2010 & 1/28/2010. No documentation found to justify billing. Individual #2 December 2009 • The Agency billed 24 units of Community Access from on 12/21/2009. No documentation found to justify billing. January 2010 • The Agency billed 132 units of Community Access from on 1/04/2010 through 1/25/2010. No documentation found to justify billing. Individual #3 January 2010 • The Agency billed 10 units of Community Access on 1/24/2010. No documentation found to justify billing.		

Tag # 5I44 AH Reimbursement	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care. **B. Billable Activities** (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours. (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 3 of 3 individuals. Individual #1 February 2010 • The Agency billed 68 units of Adult Habilitation from 2/11/2009 through 2/20/2009. No documentation found to justify billing. Individual #2 February 2010 • The Agency billed 80 units of Adult Habilitation from 2/17/2010 through 2/26/2010. No documentation found to justify billing. Individual #3 January 2010 • The Agency billed a total of 74 units of Adult Habilitation on 1/24, 28, 29 & 30. No documentation found to justify billing.		