



Date: September 14, 2012

To: Johnny Sanchez, Director of Operations/Service Coordinator  
 Provider: Mis Amigos Family Services, LLC  
 Address: 109 East Main Street  
 State/Zip: Tucumcari, NM 88401

E-mail Address: [jsanchez@misamigosfamilyservices.com](mailto:jsanchez@misamigosfamilyservices.com)

CC: Sheryl Aspelin, Executive Director/Board Chair  
 Board Chair [saspelin@misamigosfamilyservices.com](mailto:saspelin@misamigosfamilyservices.com)

Region: Southeast  
 Survey Date: July 30 – August 1, 2012  
 Program Surveyed: Developmental Disabilities Waiver  
 Service Surveyed: Community Living Supports (Supported Living, Family Living & Independent Living) & Community Inclusion Supports (Adult Habilitation, Community Access & Supported Employment)

Survey Type: Initial  
 Team Leader: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
 Team Members: Mari Chavez, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Sanchez;

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

**Determination of Compliance:**

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

***Compliance with all Conditions of Participation.***

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



**DIVISION OF HEALTH IMPROVEMENT • QUALITY MANAGEMENT BUREAU**

5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108  
 (505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

QMB Report of Findings – Mis Amigos Family Services, LLC – Southeast Region – July 30 – August 1, 2012

Survey Report #: Q.13.1.DDW.08622868.4.001.INT.1.258

**Plan of Correction:**

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

**Submission of your Plan of Correction:**

Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. (See attachment "A" for additional guidance in completing the Plan of Correction).

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

- 1. Quality Management Bureau, Attention: Plan of Correction Coordinator  
5301 Central Ave. NE Suite 400 Albuquerque, NM 87108**
- 2. Developmental Disabilities Supports Division Regional Office for region of service surveyed**

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

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

**Request for Informal Reconsideration of Findings (IRF):**

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

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

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

Please call the Plan of Correction Coordinator at 505-699-9356 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

*Deb Russell, BS*

Deb Russell, BS  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

|   |   |
|---|---|
| Entrance Conference Date:                 | July 30, 2012   |
| Present:                                  | <b><u>Mis Amigos Family Services, LLC</u></b><br>Sheryl Aspelin, Executive Director<br>Johnny Sanchez, Service Coordinator<br><br><b><u>DOH/DHI/QMB</u></b><br>Deb Russell, BS, Team Lead/Healthcare Surveyor<br>Mari Chavez, BSW, Healthcare Surveyor  |
| Exit Conference Date:                     | August 1, 2012  |
| Present:                                  | <b><u>Mis Amigos Family Services, LLC</u></b><br>Sheryl Aspelin, Executive Director<br>Johnny Sanchez, Service Coordinator<br><br><b><u>DOH/DHI/QMB</u></b><br>Deb Russell, BS, Team Lead/Healthcare Surveyor<br>Mari Chavez, BSW, Healthcare Surveyor<br><br><b><u>DDSD - Southeast Regional Office</u></b><br>Brianna Massey, by telephone conference |
| Total Homes Visited                       | Number: 4   |
| ❖ Supported Homes Visited                 | Number: 2   |
| ❖ Family Homes Visited                    | Number: 2   |
| Administrative Locations Visited          | Number: 1   |
| Total Sample Size                         | Number: 5<br>0 - Jackson Class Members<br>5 - Non-Jackson Class Members<br>2 - Supported Living<br>2 - Family Living<br>1 - Independent Living<br>5 - Adult Habilitation<br>3 - Community Access<br>2 - Supported Employment  |
| Persons Served Records Reviewed           | Number: 5   |
| Persons Served Interviewed                | Number: 5   |
| Direct Support Personnel Interviewed      | Number: 6   |
| Direct Support Personnel Records Reviewed | Number: 17  |
| Service Coordinator Records Reviewed      | Number: 2   |
| Administrative Files Reviewed             | <ul style="list-style-type: none"><li>• Billing Records</li><li>• Medical Records</li></ul>   |

QMB Report of Findings – Mis Amigos Family Services, LLC – Southeast Region – July 30 – August 1, 2012

- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Evacuation Drills
- Quality Assurance / Improvement Plan

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

## Attachment A

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

#### **Introduction:**

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

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

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

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

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-699-9356 or email at [Crystal.Lopez-Beck@state.nm.us](mailto:Crystal.Lopez-Beck@state.nm.us). Requests for technical assistance must be requested through your DDSD Regional Office.

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

#### **Instructions for Completing Agency POC:**

##### **Required Content**

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

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

##### **The Plan of Correction must address the required six CMS core elements to address each deficiency of the POC:**

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

- sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
  6. The POC must be signed and dated by the agency director or other authorized official.

*The following details should be considered when developing your POC:*

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

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

#### **Completion Dates**

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

#### **Initial Submission of the Plan of Correction Requirements**

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the QMB POC Coordinator, Crystal Lopez-Beck at 505-699-9356 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:
  - a. Electronically at [Crystal.Lopez-Beck@state.nm.us](mailto:Crystal.Lopez-Beck@state.nm.us) (*preferred method*)
  - b. Fax to 505-222-8661, or
  - c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approve” or “denied.”

- a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
  - b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
  - c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
  - d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

### ***POC Document Submission Requirements***

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

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. You may submit your documents by postal mail (paper hard copy or on a disc), fax, or electronically (scanned and attached to e-mails).
3. All submitted documents must be annotated; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. For billing deficiencies, you must submit:
  - a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
  - b. Copies of “void and adjust” forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

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

## QMB Determinations of Compliance

- “Compliance with Conditions of Participation”  
The QMB determination of “Compliance with Conditions of Participation,” indicates that a provider is in compliance with all ‘Conditions of Participation,’ (CoP) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals’ health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with *all* Conditions of Participation.
- “Partial-Compliance with Conditions of Participation”  
The QMB determination of “Partial-Compliance with Conditions of Participation” indicates that a provider is out of compliance with one (1) to three (3) ‘Conditions of Participation.’ This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety. The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

Providers receiving a repeat determination of ‘Partial-Compliance’ for repeat deficiencies of CoPs may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- “Non-Compliant with Conditions of Participation”:  
The QMB determination of “Non-Compliance with Conditions of Participation,” indicates a provider is significantly out of compliance with Conditions of Participation and/or has:
  - Four (4) Conditions of Participation out of compliance.
  - Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
  - Any finding of actual harm or Immediate Jeopardy.The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

Providers receiving a repeat determination of ‘Non-Compliance’ will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

## Attachment C

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

#### Introduction:

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

#### Instructions:

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

#### The following limitations apply to the IRF process:

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

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

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

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

**Agency:** Mis Amigo Family Services, LLC - Southeast Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Living Supports (Supported Living, Family Living & Independent Living) & Community Inclusion Supports (Adult Habilitation, Community Access & Supported Employment)  
**Monitoring Type:** Initial Survey  
**Date of Survey:** July 30, 2012 – August 1, 2012

| Standard of Care   | Deficiencies   | Agency Plan of Correction, On-going QA/QI & Responsible Party  | Date Due  |
|--|--|--|-----------|
| <p><b>CMS Assurance – Service Plans: ISP Implementation</b> – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</p>   |  |  |           |
| <p><b>Tag # 1A08 Agency Case File</b></p>  | <p><b>Standard Level Deficiency</b></p>  |  |           |
| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br/> <b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> 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.<br/> <b>D. Provider Agency Case File for the Individual:</b> 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:<br/>           (1) Emergency contact information, including the</p> | <p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 1 of 5 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• <b>ISP Teaching &amp; Support Strategies</b> <ul style="list-style-type: none"> <li>◦ <i>Individual #3 - TASS not found for the following Action Steps:</i> <ul style="list-style-type: none"> <li>➢ Take 4 out of town trips – “Plan and go on 4 out of town trips.”</li> </ul> </li> </ul> </li> </ul> | <p><b>Provider:</b><br/>           State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b><br/>           Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p> | <p>  </p> |

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| <p>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;</p> <p>(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);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(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</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p> |  |  |  |
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**NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:**

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

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



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| <p>play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities.<br/>[05/03/94; 01/15/97; Recompiled 10/31/01]</p> | <p><b>Outcomes:</b></p> <p>Individual #3</p> <ul style="list-style-type: none"> <li>• None found for 1/2012 - 6/2012</li> </ul> <p>Individual #4</p> <ul style="list-style-type: none"> <li>• None found regarding: "Learn new skill," for 11/2011 – 6/2012</li> </ul> <p><b>Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #3</p> <ul style="list-style-type: none"> <li>• None found for 4/2012 - 6/2012</li> </ul> <p><b>Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #5</p> <ul style="list-style-type: none"> <li>• None found regarding: "Volunteer position," for 4/2012 – 5/2012</li> </ul> <p><b>Residential Files Reviewed:</b></p> <p><b>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #2</p> <ul style="list-style-type: none"> <li>• None found for 7/1/2012 – 7/30/2012</li> </ul> |  |  |
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| <p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> <li>(a) The name of the individual;</li> <li>(b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;</li> <li>(c) Diagnosis for which the medication is prescribed;</li> <li>(d) Dosage, frequency and method/route of delivery;</li> <li>(e) Times and dates of delivery;</li> <li>(f) Initials of person administering or assisting with medication; and</li> <li>(g) An explanation of any medication irregularity, allergic reaction or adverse effect.</li> <li>(h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> <li>(i) Observable signs/symptoms or circumstances in which the medication is to be used, and</li> <li>(ii) Documentation of the effectiveness/result of the PRN delivered.</li> </ul> </li> <li>(i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated</li> </ul> |  |  |  |
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| <p>copy must be placed in the agency file on a weekly basis.</p> <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and</p> <p>(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.</p> |  |  |  |
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| Standard of Care   | Deficiencies   | Agency Plan of Correction, On-going QA/QI & Responsible Party  | Date Due  |
|--|--|--|-----------|
| <b>CMS Assurance – Qualified Providers</b> – <i>The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.</i>  |  |  |           |
| <b>Tag # 1A11.1 Transportation Training</b>  | <b>Standard Level Deficiency</b>   |  |           |
| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> 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...</p> <p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date:</b> March 1, 2007</p> <p><b>II. POLICY STATEMENTS:</b></p> <p>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:</p> <ol style="list-style-type: none"> <li>1. Operating a fire extinguisher</li> <li>2. Proper lifting procedures</li> <li>3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat)</li> <li>4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines</li> </ol> | <p>Based on record review, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 2 of 17 Direct Support Personnel.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> <li>• Transportation (DSP #43 &amp; 56)</li> </ul> | <p><b>Provider:</b><br/>State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b><br/>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p> | <p>  </p> |

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| <p>for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)</p> <p>5. Operating wheelchair lifts (if applicable to the staff's role)</p> <p>6. Wheelchair tie-down procedures (if applicable to the staff's role)</p> <p>7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)</p> |  |  |  |
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| <p><b>Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p> <p>D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.</p> <p>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</p> <p>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</p> <p>G. Staff shall be certified in a DDS-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDS-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.</p> <p>H. Staff shall complete and maintain certification in a DDS-approved medication course in accordance with the DDS Medication Delivery Policy M-001.</p> <p>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 service.</p> |  |  |  |
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| <p>individual;</p> <p>(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and</p> <p>(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.</p> <p>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:</p> <ul style="list-style-type: none"> <li>(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;</li> <li>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</li> <li>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</li> </ul> <p><b>Department of Health (DOH) Developmental</b></p> |  |  |  |
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**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.



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| <p>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.</p> <p>E. <b>Documentation for other staff.</b> 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.</p> <p>F. <b>Consequences of noncompliance.</b> 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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br/> <b>Chapter 1.IV. General Provider Requirements. D. Criminal History Screening:</b> 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</p> |  |  |  |
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Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.



competent and qualified staff.  
C. Staff shall complete training on DOH-  
approved incident reporting procedures in  
accordance with 7 NMAC 1.13.



requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.

| Standard of Care  | Deficiencies   | Agency Plan of Correction, On-going QA/QI & Responsible Party  | Date Due  |
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| <p><b>CMS Assurance – Health and Welfare</b> – <i>The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.</i></p>   |  |  |           |
| <p><b>Tag # 1A09 Medication Delivery (MAR) - Routine Medication</b></p>   | <p><b>Standard Level Deficiency</b></p>  |  |           |
| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br/> <b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> 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.<br/> <b>E. Medication Delivery:</b> Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDS Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.<br/><br/> (2) When required by the DDS Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:<br/> (a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and</p> | <p>Medication Administration Records (MAR) were reviewed for the months of May, June &amp; July 2012.</p> <p>Based on record review, 1 of 4 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #2<br/> July 2012<br/> Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Diamox 250mg (1 time daily)</li> <li>• Fish Oil 1000mg (2 times daily)</li> <li>• Oystcal 500mg (2 times daily)</li> </ul> | <p><b>Provider:</b><br/> State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b><br/> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p> | <p>  </p> |

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| <p>generic name of the medication, diagnosis for which the medication is prescribed;</p> <p>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p><b>NMAC 16.19.11.8 MINIMUM STANDARDS:</b><br/> <b>A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</b></p> <p>(d) The facility shall have a Medication</p> |  |  |  |
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| <p>Administration Record (MAR) documenting medication administered to residents, <b>including over-the-counter medications.</b><br/> This documentation shall include:</p> <ul style="list-style-type: none"> <li>(i) Name of resident;</li> <li>(ii) Date given;</li> <li>(iii) Drug product name;</li> <li>(iv) Dosage and form;</li> <li>(v) Strength of drug;</li> <li>(vi) Route of administration;</li> <li>(vii) How often medication is to be taken;</li> <li>(viii) Time taken and staff initials;</li> <li>(ix) Dates when the medication is discontinued or changed;</li> <li>(x) The name and initials of all staff administering medications.</li> </ul> <p><b>Model Custodial Procedure Manual</b><br/> <b>D. Administration of Drugs</b><br/> Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications.<br/> Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> <li>➤ symptoms that indicate the use of the medication,</li> <li>➤ exact dosage to be used, and</li> <li>➤ the exact amount to be used in a 24 hour period.</li> </ul> |  |  |  |
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| <p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p><b>NMAC 16.19.11.8 MINIMUM STANDARDS:<br/>A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</b></p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, <b>including over-the-counter medications.</b> This documentation shall include:</p> |  |  |  |
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| <p>(i) Name of resident;<br/> (ii) Date given;<br/> (iii) Drug product name;<br/> (iv) Dosage and form;<br/> (v) Strength of drug;<br/> (vi) Route of administration;<br/> (vii) How often medication is to be taken;<br/> (viii) Time taken and staff initials;<br/> (ix) Dates when the medication is discontinued or changed;<br/> (x) The name and initials of all staff administering medications.</p> <p><b>Model Custodial Procedure Manual</b><br/> <b>D. Administration of Drugs</b><br/> Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications.<br/> Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> <li>➤ symptoms that indicate the use of the medication,</li> <li>➤ exact dosage to be used, and</li> <li>➤ the exact amount to be used in a 24 hour period.</li> </ul> <p><b>Department of Health</b><br/> <b>Developmental Disabilities Supports</b><br/> <b>Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006</b><br/> <b>F. PRN Medication</b><br/> 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure</p> |  |  |  |
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| <p>that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.</p> <p>4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).</p> <p><b>H. Agency Nurse Monitoring</b></p> <p>1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication.</p> |  |  |  |
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| <p><b>Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:</b><br/> <b>Medication Assessment and Delivery Procedure Eff Date: November 1, 2006</b></p> <p>C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).</p> <p>a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.</p> <p>5. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).</p> |  |  |  |
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| <p><b>IV. POLICY STATEMENT - Human Rights</b><br/>Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.</p> <p>Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:</p> <ul style="list-style-type: none"> <li>• Aversive Intervention Prohibitions</li> <li>• Psychotropic Medications Use</li> <li>• Behavioral Support Service Provision.</li> </ul> <p>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.</p> <p><b>A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS</b><br/>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.</p> <p>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.</p> <p>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.</p> |  |  |  |
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**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).



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| <p><b>CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS</b></p> <p><b>D. Scope of DDS Agreement</b></p> <p>(4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite;</p> <p><b>NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER</b></p> <p><b>ELIGIBLE PROVIDERS:</b></p> <p><b>I. Qualifications for community living service providers:</b> There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards.</p> <p>(1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.</p> |  |  |  |
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| <p>detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p> <p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p> |  |  |  |
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**NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:**

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

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



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| <p>unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.</p> | <ul style="list-style-type: none"><li>• Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#4 &amp; 5)</li></ul> |  |  |
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| Standard of Care  | Deficiencies  | Agency Plan of Correction, On-going QA/QI & Responsible Party  | Date Due |
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| <b>CMS Assurance – Medicaid Billing/Reimbursement/Financial Accountability</b> – <i>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</i>  |   |  |          |
| <b>Tag # 5136 Community Access Reimbursement</b>  | <b>Standard Level Deficiency</b>  |  |          |
| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> 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.</p> <p><b>B. Billable Units:</b> 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:</p> <ol style="list-style-type: none"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ol> <p><b>MAD-MR: 03-59 Eff 1/1/2004</b><br/> <b>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b></p> | <p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 2 of 3 individuals.</p> <p>Individual #2<br/> June 2012</p> <ul style="list-style-type: none"> <li>• The Agency billed 12 units of Community Access (H2021 U1) on 6/21/2012. Documentation received accounted for 0 units.</li> </ul> <p>Individual #3<br/> April 2012</p> <ul style="list-style-type: none"> <li>• The Agency billed 46 units of Community Access (H2021 U1) on 4/19/2012. Documentation received accounted for 0 units.</li> </ul> | <p><b>Provider:</b><br/> State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b><br/> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p> |          |

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| <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br/> <b>CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS</b><br/> <b>G. Reimbursement</b><br/> (1) Billable Unit: A billable unit is defined as one-quarter hour of service.</p> <p>(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:</p> <ul style="list-style-type: none"> <li>(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;</li> <li>(b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and</li> <li>(c) Non face-to-face hours do not exceed 10% of the monthly billable hours.</li> </ul> <p>(3) Non-Billable Activities: Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:</p> <ul style="list-style-type: none"> <li>(a) Time and expense for training service</li> </ul> |  |  |  |
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| <p>personnel;<br/>(b) Supervision of agency staff;<br/>(c) Service documentation and billing activities; or<br/>(d) Time the individual spends in segregated facility-based settings activities.</p> |  |  |  |
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| <p>recoupment.</p> <p>Developmental Disabilities (DD) Waiver<br/>Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 XVI. REIMBURSEMENT</b></p> <p><b>A. Billable Unit.</b> A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care.</p> <p><b>B. Billable Activities</b></p> <p>(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.</p> <p>(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</p> |  |  |  |
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Date: November 20, 2012

To: Johnny Sanchez, Director of Operations/Service Coordinator  
Provider: Mis Amigos Family Services, LLC  
Address: 109 East Main Street  
State/Zip: Tucumcari, NM 88401  
E-mail Address: [jsanchez@misamigosfamilyservices.com](mailto:jsanchez@misamigosfamilyservices.com)

CC: Sheryl Aspelin, Executive Director/Board Chair  
Board Chair: [saspelin@misamigosfamilyservices.com](mailto:saspelin@misamigosfamilyservices.com)

Region: Southeast  
Survey Date: July 30 – August 1, 2012  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Living Supports (Supported Living, Family Living & Independent Living) & Community Inclusion Supports (Adult Habilitation, Community Access & Supported Employment)  
Survey Type: Initial

Dear Mr. Sanchez;

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

**The Plan of Correction process is now complete.**

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

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

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

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

Sincerely,

  
Crystal Lopez-Beck  
Plan of Correction Coordinator  
Quality Management Bureau/DHI

Q.13.2.DDW.08622868.4.001.INT.09.325

