

Date: July 3, 2017

To: Elizabeth Rodriguez, Executive Director  
Provider: A First Step, LLC  
Address: 540 Chama NE, Suite 4  
State/Zip: Albuquerque, New Mexico 87108

E-mail Address: [erodriguez@afirststepllc.com](mailto:erodriguez@afirststepllc.com)

Region: Metro  
Survey Date: June 19 – 21, 2017  
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012: Inclusion Supports** (Customized Community Supports)

Survey Type: Initial

Team Leader: Kandis Gomez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Rodriguez;

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.***

**No deficiencies were identified**

Please call the Quality Management Bureau at 505-222-8633, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

*Kandis Gomez, AA*

Kandis Gomez, AA  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

**DIVISION OF HEALTH IMPROVEMENT**  
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 – A First Step, LLC – Metro Region – June 19 – 21, 2017

Survey Report #: Q.17.4.DDW.42157030.5.INT.01.17.184



## Survey Process Employed:

Administrative Review Start Date:	June 19, 2017
Contact:	<b><u>A First Step, LLC</u></b> Elizabeth Rodriguez, Executive Director / Service Coordinator
	<b><u>DOH/DHI/QMB</u></b> Kandis Gomez, AA, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	June 20, 2017
Present:	<b><u>A First Step, LLC</u></b> Elizabeth Rodriguez, Executive Director / Service Coordinator
	<b><u>DOH/DHI/QMB</u></b> Kandis Gomez, AA, Team Lead/Healthcare Surveyor Lora Norby, Healthcare Surveyor
Exit Conference Date:	June 21, 2017
Present:	<b><u>A First Step, LLC</u></b> Elizabeth Rodriguez, Executive Director / Service Coordinator
	<b><u>DOH/DHI/QMB</u></b> Kandis Gomez, AA, Team Lead/Healthcare Surveyor Lora Norby, Healthcare Surveyor
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 1
	Number 0 – <i>Jackson Class Members</i> 1 - <i>Non-Jackson Class Members</i>  1 - <i>Customized Community Supports</i>
Persons Served Records Reviewed	Number: 1
Persons Served Interviewed	Number: 1
Direct Support Personnel Interviewed	Number: 1
Direct Support Personnel Records Reviewed	Number: 2
Service Coordinator Records Reviewed	Number: 1 (Executive Director also performs duties as a Service Coordinator)
Administrative Interviews	Number: 1
Administrative Processes and Records Reviewed:	
	<ul style="list-style-type: none"><li>• Medicaid Billing/Reimbursement Records for all Services Provided</li><li>• Accreditation Records</li><li>• Oversight of Individual Funds</li></ul>

- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - Medication Administration Records
  - Medical Emergency Response Plans
  - Therapy Evaluations and Plans
  - Healthcare Documentation Regarding Appointments and Required Follow-Up
  - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Regis
- Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement  
DOH - Developmental Disabilities Supports Division  
DOH - Office of Internal Audit  
HSD - Medical Assistance Division  
MFEAD – NM Attorney General

## Attachment B

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

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

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

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

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in the following Service Domains.

*Case Management Services (Four Service Domains):*

- Plan of Care: ISP Development & Monitoring
- Level of Care
- Qualified Providers
- Health, Safety and Welfare

*Community Living Supports / Inclusion Supports (Three Service Domains):*

- Service Plans: ISP Implementation
- Qualified Provider
- Health, Safety and Welfare

### Conditions of Participation (CoPs)

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

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP (See the next section for a list of CoPs). The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for

significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

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

**Service Domain: Plan of Care ISP Development & Monitoring**

Condition of Participation:

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

Condition of Participation:

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

**Service Domain: Level of Care**

Condition of Participation:

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

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

**Service Domain: Qualified Providers**

Condition of Participation:

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

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

**Service Domain: Service Plan: ISP Implementation**

Condition of Participation:

5. **ISP Implementation:** Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes / action step.

**Service Domain: Health, Welfare and Safety**

Condition of Participation:

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

Condition of Participation:

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

## QMB Determinations of Compliance

### Compliance with Conditions of Participation

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

### Partial-Compliance with Conditions of Participation

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

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

### Non-Compliance with Conditions of Participation

The QMB determination of *Non-Compliance with Conditions of Participation* indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains and/or 6 or more Condition of Participation level deficiencies overall, as well as widespread Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

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

**Agency:** A First Step, LLC - Metro Region  
**Program:** Developmental Disabilities Waiver  
**Service:** 2012: Inclusion Supports (Customized Community Supports)  
**Monitoring Type:** Initial Survey  
**Survey Date:** June 19 – 21, 2017

**Service Domain: Medicaid Billing/Reimbursement** – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

**TAG #1A12**  
**All Services Reimbursement (No Deficiencies Found)**

**NMAC 8.302.1.17 Effective Date 9-15-08**

**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.

**Detail Required in Records** - Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed, diagnosis and medical necessity of any service . . . Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.

**Services Billed by Units of Time -**

Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.

**Records Retention** - A provider who receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

- (1) treatment or care of any eligible recipient
- (2) services or goods provided to any eligible recipient
- (3) amounts paid by MAD on behalf of any eligible recipient; and
- (4) any records required by MAD for the administration of Medicaid.

Billing for **2012: Inclusion Supports** (Customized Community Supports) services was reviewed for 1 of 1 individuals. *Progress notes and billing records supported billing activities for the months of March, April and May 2017.*