

Date: January 19, 2010

To: Mike Renaud, Administrator  
Provider: PMS-SHIELD, Inc.  
Address: 2015 E 12<sup>th</sup> Street  
State/Zip: Farmington, NM. 87401

E-mail Address: mike\_renaud@pmsnet.org

CC: Martha Wooten, NW Regional Director  
E-Mail Address: martha-wooten@pmsnet.org

Region: Northwest  
Survey Date: December 14 – 16, 2009  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Inclusion (Adult Habilitation, Community Access & Supported Employment)  
Survey Type: Routine  
Team Leader: Barbara Czinger, MSW, LISW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Stephanie Martinez de Berenger, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Cathy Saxton, DDSD NW Regional Case Manager Coordinator

Dear Mr. Renaud,

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 issuing your agency a “STANDARD” rating for basic compliance with DDSD Standards and regulations.

**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.

*“Assuring safety and quality of care in New Mexico’s health facilities and community-based programs.”*

**David Rodriguez, Division Director • Division of Health Improvement**

Division of Health Improvement • Quality Management Bureau • 5301 Central Ave NE • Suite 400 • Albuquerque, New Mexico 87108  
(505) 222-8633 • FAX: (505) 222-8661

DHI Quality Review Survey Report – PMS-SHIELD, Inc. - Northwest Region – December 14 – 16, 2009

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 505-476-9023, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,



Barbara Czinger, MSW, LISW  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: December 14, 2009

Present: **PMS-SHIELD, Inc.**  
Gina Sanchez, Service Coordinator/Day Services Manager

**DOH/DHI/QMB**  
Barbara Czinger, MSW, LISW, Team Lead/Healthcare Surveyor  
Nadine Romero, LBSW, Healthcare Surveyor  
Stephanie Martinez de Berenger, MPA, Healthcare Surveyor

**DDSD - NW Regional Office**  
Cathy Saxton, Case Manager Coordinator

Exit Conference Date: December 16, 2009

Present: **PMS-SHIELD, Inc.**  
Mike Renaud, Administrator  
Martha Wooten, NW Regional Director  
Gina Sanchez, Service Coordinator/Day Services Manager

**DOH/DHI/QMB**  
Barbara Czinger, MSW, LISW, Team Lead/Healthcare Surveyor  
Nadine Romero, LBSW, Healthcare Surveyor  
Stephanie Martinez de Berenger, MPA, Healthcare Surveyor

**DDSD - NW Regional Office**  
Cathy Saxton, Case Manager Coordinator  
Dennis O'Keefe, Community Coordinator (by phone)

Administrative Locations Visited Number: 1

Total Sample Size Number: 11  
2 - Jackson Class Members  
9 - Non-Jackson Class Members  
8 - Adult Habilitation  
8 - Community Access  
9 - Supported Employment

Persons Served Interviewed Number: 3

Persons Served Observed Number: 8 (Five were unavailable for interviews due to work or not in attendance, 2 did not respond to surveyors, and one was hospitalized at the time of the on-site survey)

Records Reviewed (Persons Served) Number: 11

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
- Nursing personnel files
- 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

## 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
  - DDS 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 DDS 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 DDS 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.

## 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 DDS 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 than 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 than 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 than 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 DDS Contract unit of the "Provisional" approval rating.

## **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:** PMS-Shield, Inc. – Northwest Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Inclusion (Adult Habilitation, Community Access & Supported Employment)  
**Monitoring Type:** Routine Survey  
**Date of Survey:** December 14 – 16, 2009

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<p><b>Tag # 1A05 (CoP) General Requirements</b></p> <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>A. General Requirements:</b></p> <p>(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 DDS standards 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.</p>	<p><b>Scope and Severity Rating: F</b></p> <p>Based on record review, the Agency failed to review and update its written policies and procedures every three years or as needed.</p> <p>The following policies and procedures provided during the on-site survey (12/14/2009) showed no evidence of being reviewed every three years or being updated as needed:</p> <ul style="list-style-type: none"> <li>• Reportable Events - Last reviewed and/or revised March 2006.</li> <li>• Travel Safety/Vehicle Reporting/Vehicle Safety - Last reviewed and/or revised March 2006.</li> <li>• Emergency Evacuation - Last reviewed and/or revised March 2006.</li> <li>• Medication Refusal - Last reviewed and/or revised May 2006.</li> <li>• Medication Storage – Last reviewed and/or revised May 2006.</li> <li>• Medical Emergencies – Last reviewed and/or revised May 2006.</li> <li>• Medication Assistance – Last reviewed and/or revised May 2006.</li> <li>• Suspected Abuse, Neglect or Misappropriation –</li> </ul>		

	<p>Last reviewed and/or revised May 2006.</p> <ul style="list-style-type: none"><li>• Emergency On-Call – Last reviewed and/or revised November 2006.</li></ul>		
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Tag # 1A08 Agency Case File	Scope and Severity Rating: A		
<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>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:</p> <ol style="list-style-type: none"> <li>(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;</li> <li>(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);</li> <li>(3) Progress notes and other service delivery documentation;</li> <li>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</li> <li>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the</li> </ol>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 1 of 11 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• Positive Behavioral Plan (#9)</li> <li>• Positive Behavioral Crisis Plan (#9)</li> </ul>		

<p>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> <ul style="list-style-type: none"> <li>(a) Complete file for the past 12 months;</li> <li>(b) ISP and quarterly reports from the current and prior ISP year;</li> <li>(c) Intake information from original admission to services; and</li> <li>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</li> </ul>			
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Tag # 1A11 (CoP) Transportation Training	Scope and Severity Rating: E		
<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>G. Transportation:</b> 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:</p> <ol style="list-style-type: none"> <li>(1) Drivers' requirements,</li> <li>(2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions,</li> <li>(3) Vehicle maintenance and safety inspections,</li> <li>(4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures,</li> <li>(5) Emergency Plans, including vehicle evacuation techniques,</li> <li>(6) Documentation, and</li> <li>(7) Accident Procedures.</li> </ol> <p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy</b> Training Requirements for Direct Service Agency</p>	<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 5 of 17 Direct Service Personnel.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> <li>• Transportation (DSP #12, 16, 19, 22 &amp; 26)</li> </ul>		

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 # 1A15 Healthcare Documentation	Scope and Severity Rating: E		
<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 - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:</b> Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p><b>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</b></p> <p>(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:</p> <ul style="list-style-type: none"> <li>(i) Community living services provider agency;</li> <li>(ii) Private duty nursing provider agency;</li> <li>(iii) Adult habilitation provider agency;</li> <li>(iv) Community access provider agency; and</li> <li>(v) Supported employment provider agency.</li> </ul> <p>(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</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 3 of 11 individuals</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• Health Assessment Tool (#4)</li> <li>• Medication Administration Assessment Tool (#4)</li> <li>• <b>Quarterly Nursing Review of HCP/Crisis Plans:</b> <ul style="list-style-type: none"> <li>◦ None found for 11/2008 - 11/2009 (#11)</li> </ul> </li> <li>• <b>Special Health Care Needs:</b> <ul style="list-style-type: none"> <li>• Nutritional Evaluation</li> <li>◦ Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> </ul>		

<p>caregiver upon request.</p> <p>(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.</p> <p>(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).</p> <p>(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 <i>subjective</i> information including the individual complaints, signs and symptoms noted by staff, family members or other team members; <i>objective</i> information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); <i>assessment</i> of the clinical status, and <i>plan</i> of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p><b>(2) Health related plans</b></p> <p>(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.</p>			
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<p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(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.</p> <p>(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.</p> <p>(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):</p> <p>(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.</p> <p>(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.</p> <p>(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.</p>			
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<p>(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.</p> <p>(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.</p> <p>(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.</p> <p>(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.</p> <p>(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.</p> <p><b>(4) General Nursing Documentation</b></p> <p>(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.</p> <p>(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.</p>			
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Tag # 1A22 Staff Competence	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> 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.</p> <p><b>F. Qualifications for Direct Service Personnel:</b> The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</p> <p>(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;</p> <p>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</p> <p>(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;</p> <p>(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy</p>	<p>Based on interview, the Agency failed to ensure that training competencies were met for 4 of 7 Direct Service Personnel.</p> <p><b>When DSP were asked if they received training on the Individual’s Speech Therapy Plan and what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>DSP #26 stated, “No, no training.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #1)</li> </ul> <p><b>When DSP were asked if they received training on the Individual’s Occupational Therapy Plan and what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>DSP #26 stated, “No, I did not.” According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #1)</li> </ul> <p><b>When DSP were asked if they received training on the Individual’s Physical Therapy Plan and what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>DSP #26 stated, “He doesn’t have PT”. According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan). (Individual #1)</li> </ul> <p><b>When DSP were asked if they received training on the Individual’s Crisis Plans and what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>DSP #20 stated, “No”. As indicated by the Agency file, the Individual has Crisis Plans for Pulmonary embolism. (Individual #2)</li> </ul>	

<p>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> <p>(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;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p>	<p><b>When DSP were asked if they had received training regarding the individual's Seizure Disorder, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #17 stated, "I read the book." According to the ISP, the individual has a diagnosis of Seizures. (Individual #9)</li> </ul> <p><b>When DSP were asked if they had received training on the Individual's Diabetes, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #13 stated, "There is nothing in the HCP or Crisis Plan". According to the ISP, the individual has a diagnosis of Diabetes. (Individual #3)</li> </ul>		
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Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E		
<p><b>NMAC 7.1.12.8</b>  <b>REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:</b> 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.</p> <p>A. <b>Provider requirement to inquire of registry.</b> 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.</p> <p>B. <b>Prohibited employment.</b> 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.</p> <p>D. <b>Documentation of inquiry to registry.</b> 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.</p>	<p>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 4 of 19 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> <li>• #15 – Date of hire 11/17/2008</li> <li>• #21 – Date of hire 01/14/2008</li> <li>• #24 – Date of hire 06/16/2008</li> <li>• #26 – Date of hire 10/12/2009</li> </ul>		

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.

<b>Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training</b>	<b>Scope &amp; Severity Rating: D</b>		
<p><b>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> 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.</p> <p><b>D. Training Documentation:</b> 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.</p> <p><b>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</b></p> <p><b>II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p>	<p>Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 1 of 19 Agency Personnel.</p> <ul style="list-style-type: none"> <li>• Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers' Property) (#18)</li> </ul>		

<b>Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training</b>	<b>Scope &amp; Severity Rating: E</b>		
<p><b>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> 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.</p> <p><b>E. Consumer and Guardian Orientation Packet:</b> 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.</p>	<p>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 11 individuals.</p> <ul style="list-style-type: none"> <li>• Parent/Guardian Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers' Property) (#1, 3 &amp; 7)</li> </ul>		



Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: A		
<p><b>NMAC 7.26.3.6</b>  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].</p> <p><b>NMAC 7.26.3.13 Client Complaint Procedure Available.</b> 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]</p> <p><b>NMAC 7.26.4.13 Complaint Process:</b>  <b>A. (2).</b> The service provider's complaint or grievance procedure shall provide, at a minimum, that: <b>(a)</b> the client is notified of the service provider's complaint or grievance procedure</p>	<p>Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 11 individuals.</p> <ul style="list-style-type: none"> <li>Grievance/Complaint Procedure Acknowledgement (#7)</li> </ul>		

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: D		
<p><b>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP.</b> 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.</p> <p>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.</p> <p>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]</p>	<p>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 1 of 11 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <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 10/2008 - 10/2009</li> </ul>		

Tag # 1A36 SC Training	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> 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.</p> <p><b>C. Orientation and Training Requirements:</b> Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training <b>Requirements for Direct Support Staff and Internal Service Coordinators</b> Serving Individuals with Developmental Disabilities to include the following:</p> <p>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 2 Service Coordinators.</p> <p>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</p> <ul style="list-style-type: none"> <li>• Pre-Service Manual (SC #30)</li> </ul>		

Tag # 5109 - IDT Coordination	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>B. IDT Coordination</b></p> <p>(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</p> <p>(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.</p>	<p>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 11 receiving Community Inclusion Services.</p> <p>The following documents were not found, incomplete and /or not current:</p> <ul style="list-style-type: none"> <li>• <b>Crisis Plans</b> <ul style="list-style-type: none"> <li>• Asthma               <ul style="list-style-type: none"> <li>◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> <li>• Allergies               <ul style="list-style-type: none"> <li>◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> <li>• Consistent Routine               <ul style="list-style-type: none"> <li>◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> <li>• GERD               <ul style="list-style-type: none"> <li>◦ Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan.</li> <li>◦ Individual #11 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> <li>• Hypertension               <ul style="list-style-type: none"> <li>◦ Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> <li>• Positioning               <ul style="list-style-type: none"> <li>◦ Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> </ul> </li> </ul>		

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>E. Provider Agency Reporting Requirements:</b> 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:</p> <ol style="list-style-type: none"> <li>(1) Identification and implementation of a meaningful day definition for each person served;</li> <li>(2) Documentation summarizing the following: <ol style="list-style-type: none"> <li>(a) Daily choice-based options; and</li> <li>(b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP.</li> </ol> </li> <li>(3) Significant changes in the individual's routine or staffing;</li> <li>(4) Unusual or significant life events;</li> <li>(5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;</li> <li>(6) Record of personally meaningful community inclusion;</li> <li>(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</li> <li>(8) Any additional reporting required by DDSD.</li> </ol>	<p>Based on record review, the Agency failed to complete quarterly reports as required for 4 of 11 individuals receiving Community Inclusion services.</p> <p><b>Adult Habilitation Quarterly Reports</b></p> <ul style="list-style-type: none"> <li>• Individual #8 - None found for 9/2009 - 11/2009</li> </ul> <p><b>Supported Employment Quarterly Reports</b></p> <ul style="list-style-type: none"> <li>• Individual #1 - None found for 4/2009 - 9/2009</li> <li>• Individual #2 - None found for 3/2009 - 9/2009</li> <li>• Individual #3 - None found for 10/2008 - 9/2009</li> </ul>		

Tag # 5I22 SE Agency Case File	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</b></p> <p><b>D. Provider Agency Requirements</b></p> <p>(1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.</p> <p>(2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:</p> <p>(a) Quarterly progress reports;</p> <p>(b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD;</p> <p>(c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks</p>	<p>Based on record review, the Agency failed to maintain a confidential case file for each individual for 8 of 9 individuals receiving Supported Employment Services.</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• Vocational Assessment (#6 &amp; 8)</li> <li>• Career Development Plan (#7)</li> <li>• Required Certificates &amp; Documentation <ul style="list-style-type: none"> <li>◦ DVR Decision (#1, 2, 7 &amp; 10)</li> <li>◦ Documentation of Earnings. (#1, 2, 3, 4, 6, 7, 8 &amp; 10)</li> </ul> </li> </ul>		

including the individual, as well and a review and reporting mechanism for mutual accountability; and

(d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973.

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

**Policy Title: Vocational Assessment Profile**

**Policy Eff July 16, 2008**

**I. PURPOSE**

The intent of the policy is to ensure that individuals are identified who could benefit from Vocational Assessment Profiles (VAPs) and are supported to access this support.

**II. POLICY STATEMENT**

Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures.

Tag # 5I25 SE Reimbursement	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</b></p> <p><b>E. Reimbursement</b></p> <p>(1) Billable Unit:</p> <p>(a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job.</p> <p>(b) The <b>billable unit for Individual Supported Employment</b> is one hour with a maximum of four hours a month. The Individual Supported Employment hourly rate is for face-to-face time which is supported by non face-to-face activities as specified in the ISP and the performance based contract as negotiated annually with the provider agency. Individual Supported Employment is a minimum of one unit per month. If an individual needs less than one hour of face-to-face service per month the IDT Members shall consider whether Supported Employment Services need to be continued. Examples of non face-to-face services include:</p> <ul style="list-style-type: none"> <li>(i) Researching potential employers via telephone, Internet, or visits;</li> <li>(ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents;</li> <li>(iii) Arranging appointments for job tours, interviews, and job trials;</li> <li>(iv) Documenting job search and acquisition progress;</li> <li>(v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual's progress, needs and satisfaction; and</li> <li>(vi) Meetings with individual surrounding job development or retention not at the employer's site.</li> </ul> <p>(c) Intensive Supported Employment services are</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 1 of 9 individuals</p> <p>Individual #11 August 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 08/01/2009 through 08/31/2009. Documentation received accounted for 0 units.</li> </ul> <p>September 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 09/01/2009 through 09/30/2009. Documentation received accounted for 0 units.</li> </ul> <p>October 2009</p> <ul style="list-style-type: none"> <li>• The Agency billed 4 units of Supported Employment from 10/01/2009 through 10/31/2009. Documentation received accounted for 0 units.</li> </ul>		



intended for individuals who need one-to-one, face-to-face support for 32 or more hours per month. The billable unit is one hour.

(d) Group Supported Employment is a fifteen-minute unit.

(e) Self-employment is a fifteen minute unit.

(4) Billable Activities include:

(a) Activities conducted within the scope of services;

(b) Job development and related activities for up to ninety (90) calendar days) that result in employment of the individual for at least thirty (30) calendar days; and

(c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDSD Regional Office.

Tag # 5I36 CA Reimbursement	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS</b></p> <p><b>G. Reimbursement</b></p> <p>(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> <p>(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;</p> <p>(b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and</p> <p>(c) Non face-to-face hours do not exceed 10% of the monthly billable hours.</p> <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> <p>(a) Time and expense for training service personnel;</p> <p>(b) Supervision of agency staff;</p> <p>(c) Service documentation and billing activities; or</p> <p>(d) Time the individual spends in segregated facility-based settings activities.</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 3 of 8 individuals.</p> <p>Individual #4 August 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 126 units of Community Access from 08/01/2009 through 08/31/2009. Documentation received accounted for 117 units.</li> </ul> <p>September 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 126 units of Community Access from 09/01/2009 through 09/30/2009. Documentation received accounted for 102 units.</li> </ul> <p>Individual #8 October 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 180 units of Community Access from 10/01/2009 through 10/31/2009. Documentation received accounted for 159 units.</li> </ul> <p>Individual #9 August 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 312 units of Community Access from 08/01/2009 through 08/31/2009. Documentation received accounted for 287 units.</li> </ul> <p>September 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 372 units of Community Access from 09/01/2009 through 09/30/2009. Documentation received accounted for 333 units.</li> </ul>		

Tag # 5144 AH Reimbursement	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver 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>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 5 of 8 individuals.</p> <p>Individual #4 September 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 80 units of Adult Habilitation from 09/01/2009 through 09/30/2009. Documentation received accounted for 66 units.</li> </ul> <p>Individual #5 August 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 126 units of Adult Habilitation from 08/01/2009 through 08/31/2009. Documentation received accounted for 119 units.</li> </ul> <p>Individual #7 August 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 31 units of Adult Habilitation from 08/01/2009 through 08/31/2009. Documentation received accounted for 27 units.</li> </ul> <p>Individual #8 August 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 57 units of Adult Habilitation from 08/01/2009 through 08/31/2009. Documentation received accounted for 36 units.</li> </ul> <p>Individual #9 October 2009</p> <ul style="list-style-type: none"> <li>The Agency billed 176 units of Adult Habilitation from 10/01/2009 through 10/31/2009. Documentation received accounted for 119 units.</li> </ul>		