

Date: February 4, 2019

To: Sylvia D. Torres, Executive Director

Provider: Milagro De Vida Community Service, LLC  
Address: 1591 E. Lohman, Suite A  
City, State, Zip: Las Cruces, New Mexico 88001

E-mail Address: [sylviatorres@mdv-nm.com](mailto:sylviatorres@mdv-nm.com)

Region: Southwest  
Survey Date: September 14 – 20, 2018  
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012 & 2018:** Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports, Community Integrated Employment Services

Survey Type: Routine

Team Leader: Michele Beck, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Member: Lucio Hernandez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Monica Valdez, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Beverly Estrada, ADN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Valerie V. Valdez, MS, Bureau Chief, Division of Health Improvement/Quality Management Bureau.

Dear Sylvia D. Torres;

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:

**Non-Compliance:** This determination is based on noncompliance with 17 or more Standard Level Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any tag or any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags (*refer to Attachment D for details*). The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

**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>



The following tags are identified as Standard Level:

- Tag # 1A08.1 Administrative and Residential Case File: Progress Notes
- Tag # 1A08.3 Administrative Case File: Individual Service Plan/ISP Components
- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)
- Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)
- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements
- Tag # 1A38.1 Living Care Arrangement / Community Inclusion Reporting Requirements (Reporting Components)
- Tag # IS12 Person Centered Assessment (Inclusion Services)
- Tag # LS14.1 Residential Service Delivery Site Case File (Other Required Documentation)
- Tag # 1A37 Individual Specific Training
- Tag # 1A43.1 General Events Reporting - Individual Reporting
- Tag # 1A09 Medication Delivery - Routine Medication Administration
- Tag # 1A09.1 Medication Delivery - PRN Medication Administration
- Tag # 1A29 Complaints / Grievances – Acknowledgement
- Tag # LS06 Family Living Requirements

The following tags are identified as Condition of Participation Level:

- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare requirements)
- Tag # 1A20 Direct Support Personnel Training
- Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A09.2 Medication Delivery - Nurse Approval for PRN Medication
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)
- Tag # 1A31 Client Rights/Human Rights
- Tag # IS30 Customized Community Supports Reimbursement
- Tag # LS26 Supported Living Reimbursement

### **Plan of Correction:**

The attached Report of Findings identifies the deficiencies found during your agency's on-site 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.

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (Attachment A) for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

### **Corrective Action for Current Citation:**

- How is the deficiency going to be corrected? (i.e. obtained documents, retrain staff, individuals and/or staff no longer in service, void/adjusts completed, etc.) This can be specific to each deficiency cited or if possible an overall correction, i.e. all documents will be requested and filed as appropriate.

### **On-going Quality Assurance/Quality Improvement Processes:**

- What is going to be done on an ongoing basis? (i.e. file reviews, etc.)
- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position within your agency)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

### **Submission of your Plan of Correction:**

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

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

1. **Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator  
1170 North Solano Suite D Las Cruces, New Mexico 88001**
2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

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

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

**Billing Deficiencies:**

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

*Attention: Lisa Medina-Lujan  
HSD/OIG  
Program Integrity Unit  
1474 Rodeo Road  
Santa Fe, New Mexico 87505*

Please be advised that there is a one-week lag period for applying payments received by check to Void/Adjust claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

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

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

Request for Informal Reconsideration of Findings  
5301 Central Ave NE Suite #400  
Albuquerque, NM 87108  
Attention: IRF request

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

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

Sincerely,

*Valerie Valdez, MS*

Valerie Valdez, MS  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Administrative Review Start Date:	September 14, 2018
Contact:	<b><u>Milagro De Vida Community Service, LLC</u></b> Sylvia Torres, Executive Director  <b><u>DOH/DHI/QMB</u></b> Michele Beck, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	September 17, 2018
Present:	<b><u>Milagro De Vida Community Service, LLC</u></b> Mark Jenkins, Service Coordinator Sylvia Torres, Executive Director Virginia Flores, Office Manager  <b><u>DOH/DHI/QMB</u></b> Michele Beck, Team Lead, Healthcare Surveyor Lora Norby, Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Lucio Hernandez, AA, Healthcare Surveyor Beverly Estrada, ADN, Healthcare Surveyor
Exit Conference Date:	September 20, 2018
Present:	<b><u>Milagro De Vida Community Service, LLC</u></b> Mark Jenkins, Service Coordinator Sylvia Torres, Executive Director Marco Torres, Service Coordinator Virginia Flores, Office Manager  <b><u>DOH/DHI/QMB</u></b> Michele Beck, Team Lead, Healthcare Surveyor Lora Norby, Healthcare Surveyor Lucio Hernandez, AA, Healthcare Surveyor  <b><u>DDSD – Southwest Regional Office</u></b> Dave Brunson, Social & Community Coordinator
Administrative Locations Visited	1
Total Sample Size	7  0 - Jackson Class Members 7 - Non-Jackson Class Members  5 - Supported Living 1 - Family Living 1 - Customized In-Home Supports 3 - Community Integrated Employment Services 6 - Customized Community Supports
Total Homes Visited	4
❖ Supported Living Homes Visited	3

*Note: The following Individuals share a SL residence:*

❖ Family Living Homes Visited	1
Persons Served Records Reviewed	7
Persons Served Interviewed	4
Persons Served Observed	3 (Three Individuals chose not to participate in the interview process)
Direct Support Personnel Interviewed	7
Direct Support Personnel Records Reviewed	39
Substitute Care/Respite Personnel Records Reviewed	2
Service Coordinator Records Reviewed	3
Administrative Interviews	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
  - 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 Registry
- Human Rights Committee Notes and Meeting Minutes
- 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  
 NM Attorney General's Office

## 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 deficiencies and non-compliance.

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

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at [AmandaE.Castaneda@state.nm.us](mailto:AmandaE.Castaneda@state.nm.us). Requests for technical assistance must be requested through your Regional DDS 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 cited to prevent recurrence and information that ensures the regulation cited comes into and remains in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance (QA) Plan.

If a deficiency has already been corrected since the on-site survey, 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 following details should be considered when developing your Plan of Correction:*

**The Plan of Correction must address each deficiency cited in the Report of Findings unless otherwise noted with a "No Plan of Correction Required statement." The Plan of Correction must address the five (5) areas listed below:**

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 those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

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

- Details about how and when Individual Served, agency personnel and administrative and service delivery site 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 to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (LOC) packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

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

#### **Completion Dates**

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

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

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at [AmandaE.Castaneda@state.nm.us](mailto:AmandaE.Castaneda@state.nm.us) for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
  - a. Electronically at [AmandaE.Castaneda@state.nm.us](mailto:AmandaE.Castaneda@state.nm.us) (**preferred method**)
  - b. Fax to 575-528-5019, or
  - c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”
  - a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45-business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
  - b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.
  - c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
  - d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
  - e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

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

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



1. Your internal documents are due within a *maximum* of 45-business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If documents containing HIPAA Protected Health Information (PHI) documents must be submitted through S-Comm (Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to e-mails.
3. All submitted documents *must be annotated*; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

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

## Attachment B

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

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); 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 Assurance 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 during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. 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.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

#### Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

#### ***Service Domains and CoPs for Living Care Arrangements and Community Inclusion are as follows:***

**Service Domain: Service Plan: ISP Implementation** - *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*

##### **Potential Condition of Participation Level Tags, if compliance is below 85%:**

- **1A08.3** – Administrative Case File: Individual Service Plan / ISP Components
- **1A32** – Administrative Case File: Individual Service Plan Implementation
- **LS14** – Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- **IS14** – CCS / CIES Service Delivery Site Case File (ISP and Healthcare Requirements)

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

##### **Potential Condition of Participation Level Tags, if compliance is below 85%:**

- **1A20** - Direct Support Personnel Training
- **1A22** - Agency Personnel Competency

QMB Report of Findings – Milagro De Vida Community Service, LLC – Southwest – September 14 - 20, 2018

Survey Report #: Q.19.1.DDW.27359557.3.RTN.01.19.035

- **1A37** – Individual Specific Training

**Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):**

- **1A25.1** – Caregiver Criminal History Screening
- **1A26.1** – Consolidated On-line Registry Employee Abuse Registry

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

**Potential Condition of Participation Level Tags, if compliance is below 85%:**

- **1A08.2** – Administrative Case File: Healthcare Requirements & Follow-up
- **1A09** – Medication Delivery Routine Medication Administration
- **1A09.1** – Medication Delivery PRN Medication Administration
- **1A15.2** – Administrative Case File: Healthcare Documentation (Therap and Required Plans)

**Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):**

- **1A05** – General Requirements / Agency Policy and Procedure Requirements
- **1A07** – Social Security Income (SSI) Payments
- **1A09.2** – Medication Delivery Nurse Approval for PRN Medication
- **1A15** – Healthcare Documentation - Nurse Availability
- **1A31** – Client Rights/Human Rights
- **LS25.1** – Residential Reqtts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

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

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

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

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

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

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

## QMB Determinations of Compliance

### **Compliance:**

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. 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*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

### **Partial-Compliance with Standard Level Tags:**

The QMB determination of *Partial-Compliance with Standard Level Tags* indicates that a provider is in compliance with all Condition of Participation Level deficiencies but is out of compliance with a certain percentage of Standard Level deficiencies. This partial-compliance, if not corrected, may result in a negative outcome or the potential for more than minimal harm to individuals' health and safety. There are two ways to receive a determination of Partial Compliance with Standard Level Tags:

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.
2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

### **Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags:**

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. 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.

### **Non-Compliance:**

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. 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. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 17 or more Standard Level Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any tag.
2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Standard Level Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
COP Level Tags:	0 COP	0 COP	0 COP	0 COP	1 to 5 COP	0 to 5 CoPs	6 or more COP
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
<i>“Non-Compliance”</i>						17 or more Standard Level Tags with 75 to 100% of the Individuals in the sample cited in any tag.	Any Amount of Standard Level Tags and 6 or more Conditions of Participation Level Tags.
<i>“Partial Compliance with Standard Level tags and Condition of Participation Level Tags”</i>					Any Amount of Standard level Tags, plus 1 to 5 Conditions of Participation Level tags.		
<i>“Partial Compliance with Standard Level tags”</i>			up to 16 Standard Level Tags with 75 to 100% of the individuals in the sample cited in any tag.	17 or more Standard Level Tags with 50 to 74% of the individuals in the sample cited any tag.			
<i>“Compliance”</i>	Up to 16 Standard Level Tags with 0 to 74% of the individuals in the sample cited in any tag.	17 or more Standard Level Tags with 0 to 49% of the individuals in the sample cited in any tag.					

**Agency:** Milagro De Vida Community Service, LLC - Southwest  
**Program:** Developmental Disabilities Waiver  
**Service:** 2012 & 2018: Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports, Community Integrated Employment Services  
**Survey Type:** Routine  
**Survey Date:** September 14 – 20, 2018

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<b>Service Domain: 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.			
<b>Tag # 1A08.1 Administrative and Residential Case File: Progress Notes</b>	<b>Standard Level Deficiency</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:</b> All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.</p> <p>DD Waiver Provider Agencies are required to adhere to the following:</p> <ol style="list-style-type: none"> <li>1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.</li> <li>2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable.</li> <li>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</li> <li>4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any</li> </ol>	<p>Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 4 of 7 Individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found:</p> <p><b>Administrative Case File:</b></p> <p><b>Supported Living Progress Notes/Daily Contact Logs:</b></p> <ul style="list-style-type: none"> <li>• Individual #1 – None found for 6/9/2018.</li> </ul> <p><b>Residential Case File:</b></p> <p><b>Supported Living Progress Notes/Daily Contact Logs:</b></p> <ul style="list-style-type: none"> <li>• Individual #2 - None found for 9/9 – 15, 2018.</li> <li>• Individual #6 - None found for 9/9 – 15, 2018.</li> </ul> <p><b>Family Living Progress Notes/Daily Contact Logs:</b></p> <ul style="list-style-type: none"> <li>• Individual #3 - None found for 9/1 - 18, 2018.</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (<i>What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

QMB Report of Findings – Milagro De Vida Community Service, LLC – Southwest – September 14 - 20, 2018

<p>routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</p> <p>5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>7. All records pertaining to JCMs must be retained permanently and must be made available to DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p><b>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</b></p> <p><b>Chapter 6 (CCS) 3. Agency Requirements: 4. Reimbursement A. Record Requirements 1.</b>  ...Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...</p> <p><b>Chapter 7 (CIHS) 3. Agency Requirements: 4. Reimbursement A. 1....</b>Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...</p> <p><b>Chapter 11 (FL) 3. Agency Requirements: 4. Reimbursement A. 1....</b>Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...</p>			
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<p>by DDS to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDS and be required for use in order to better demonstrate required elements of the PCP process and ISP development. The ISP is completed by the CM with the IDT input and must be completed according to the following requirements:</p> <ol style="list-style-type: none"> <li>1. DD Waiver Provider Agencies should not recommend service type, frequency, and amount (except for required case management services) on an individual budget prior to the Vision Statement and Desired Outcomes being developed.</li> <li>2. The person does not require IDT agreement/approval regarding his/her dreams, aspirations, and desired long-term outcomes.</li> <li>3. When there is disagreement, the IDT is required to plan and resolve conflicts in a manner that promotes health, safety, and quality of life through consensus. Consensus means a state of general agreement that allows members to support the proposal, at least on a trial basis.</li> <li>4. A signature page and/or documentation of participation by phone must be completed.</li> <li>5. The CM must review a current Addendum A and DHI ANE letter with the person and Court appointed guardian or parents of a minor, if applicable.</li> </ol> <p><b>6.6.3 Additional Requirements for Adults:</b> Because children have access to other funding sources, a larger array of services are available to adults than to children through the DD Waiver. (See Chapter 7: Available Services and Individual Budget Development). The ISP Template for adults is also more extensive, including Action Plans, Teaching and Support Strategies (TSS), Written Direct Support Instructions (WDSI), and Individual Specific Training (IST) requirements.</p>			
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<p><b>6.6.3.1. Action Plan:</b> Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes. Multiple service types may be included in the Action Plan under a single Desired Outcome. Multiple Provider Agencies can and should be contributing to Action Plans toward each Desired Outcome.</p> <ol style="list-style-type: none"> <li>1. Action Plans include actions the person will take; not just actions the staff will take.</li> <li>2. Action Plans delineate which activities will be completed within one year.</li> <li>3. Action Plans are completed through IDT consensus during the ISP meeting.</li> <li>4. Action Plans must indicate under "Responsible Party" which DSP or service provider (i.e. Family Living, CCS, etc.) are responsible for carrying out the Action Step.</li> </ol> <p><b>6.6.3.2 Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI):</b> After the ISP meeting, IDT members conduct a task analysis and assessments necessary to create effective TSS and WDSI to support those Action Plans that require this extra detail. All TSS and WDSI should support the person in achieving his/her Vision.</p> <p><b>6.6.3.3 Individual Specific Training in the ISP:</b> The CM, with input from each DD Waiver Provider Agency at the annual ISP meeting, completes the IST requirements section of the ISP form listing all training needs specific to the individual. Provider Agencies bring their proposed IST to the annual meeting. The IDT must reach a consensus about who needs to be trained, at what level (awareness, knowledge or skill), and within what timeframe. (See Chapter 17.10 Individual-Specific Training for more information about IST.)</p> <p><b>6.8 ISP Implementation and Monitoring:</b> All</p>			
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<p>DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.</p> <p><b>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:</b> All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.</p> <p><b>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</b>  <b>Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDS Individual Case File Matrix policy.</p>			
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<p><b>Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy:</b> All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p><b>Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy:</b> All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p>			
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<p>purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 6: Individual Service Plan (ISP)</b></p> <p><b>6.8 ISP Implementation and Monitoring:</b> All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.</p> <p><b>Chapter 20: Provider Documentation and Client Records</b></p> <p><b>20.2 Client Records Requirements:</b> All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:</p> <ol style="list-style-type: none"> <li>1. Client records must contain all documents essential to the service being provided and</li> </ol>			
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<p>essential to ensuring the health and safety of the person during the provision of the service.</p> <p>2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable.</p> <p>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</p> <p>5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p>			
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<p>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>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 6: Individual Service Plan (ISP)</b></p> <p><b>6.8 ISP Implementation and Monitoring:</b> All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.</p> <p><b>Chapter 20: Provider Documentation and Client Records</b></p> <p><b>20.2 Client Records Requirements:</b> All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:</p> <p>8. Client records must contain all documents</p>	<p>for the needed ingredients" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</p> <ul style="list-style-type: none"> <li>• According to the Live Outcome; Action Step for "...will cook a healthy recipe" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> <li>• According to the Live Outcome; Action Step for "...will put recipes in his recipe book" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> </ul> <p>Individual #6</p> <ul style="list-style-type: none"> <li>• According to the Live Outcome/Action Step for " ...will select type of activity" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 and 8/2018.</li> <li>• According to the Live Outcome/Action Step for "...will identify and invite 3 individuals of his choice to his activity" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 and 8/2018.</li> <li>• According to the Live Outcome/Action Step for " ...will host his activity" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 and 8/2018.</li> </ul>		
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<p>essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.</p> <p>9. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices</p> <p>10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>11. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</p> <p>12. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>13. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>14. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p>	<p>Individual #7</p> <ul style="list-style-type: none"> <li>• According to the Live Outcome; Action Step for "...will research recipes" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> <li>• According to the Live Outcome; Action Step for "...will shop/cost compare for ingredients" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018.</li> </ul> <p><b>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #3</p> <ul style="list-style-type: none"> <li>• According to the Live Outcome; Action Step for "...will stand up for at least 2 minutes while bathing" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018.</li> </ul> <p><b>Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #1</p> <ul style="list-style-type: none"> <li>• According to the Work Outcome; Action Step for "...will learn new skills at day hab" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> </ul> <p>Individual #2</p> <ul style="list-style-type: none"> <li>• According to the Work/Learn Outcome; Action Step for "...will save at least \$2.00" is to be</li> </ul>		
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	<p>completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</p> <ul style="list-style-type: none"> <li>• According to the Work/Learn Outcome; Action Step for "...will make his purchase" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> </ul> <p>Individual #4</p> <ul style="list-style-type: none"> <li>• According to the Work/Learn Outcome; Action Step for "will search/choose location to volunteer" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/2018 - 8/2018.</li> <li>• According to the Work/Learn Outcome; Action Step for "will participate in volunteer job" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> <li>• According to the Fun Outcome; Action Step for "will choose an activity" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> <li>• According to the Fun Outcome; Action Step for "will participate in activity" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> </ul> <p>Individual #5</p>		
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	<ul style="list-style-type: none"> <li>• According to the Fun Outcome; Action Step for "...will choose a ceramics project" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> <li>• According to the Fun Outcome; Action Step for "...will plan for the project, set a budget, gather materials, purchase supplies, etc." is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> <li>• According to the Fun Outcome; Action Step for "...will complete the project" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> </ul> <p>Individual #6</p> <ul style="list-style-type: none"> <li>• According to the Work/Learn Outcome; Action Step for "...will take a day trip" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 and 8/2018.</li> <li>• According to the Fun Outcome; Action Step for "...will imitate 1 sign a day with hand over hand assistance" is to be completed 1 time per day. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> <li>• According to the Fun Outcome; Action Step for "...will use spontaneous sign to communicate one of his needs" is to be completed 1 time weekly. Evidence found indicated it was not being completed at the</li> </ul>		
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	<p>required frequency as indicated in the ISP for 6/2018 - 8/2018.</p> <p>Individual #7</p> <ul style="list-style-type: none"> <li>• According to the Fun Outcome; Action Step for "...will research destinations" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> <li>• According to the Fun Outcome; Action Step for "...will save \$25 towards by budget" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> </ul> <p><b>Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #1</p> <ul style="list-style-type: none"> <li>• According to the Work Outcome; Action Step for "...will work on a resume" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> <li>• According to the Work Outcome; Action Step for "...will attend DVR", is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2018 - 8/2018.</li> </ul> <p>Individual #7</p> <ul style="list-style-type: none"> <li>• According to the Work Outcome; Action Step for "...will fill out application and apply" is to be completed 1 time per week. Evidence found indicated it was not being completed at</li> </ul>		
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	the required frequency as indicated in the ISP for 6/2018- 8/2018.		
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<p>purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 6: Individual Service Plan (ISP)</b></p> <p><b>6.8 ISP Implementation and Monitoring:</b> All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.</p> <p><b>Chapter 20: Provider Documentation and Client Records</b></p> <p><b>20.2 Client Records Requirements:</b> All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:</p> <p>16. Client records must contain all documents essential to the service being provided and</p>	<ul style="list-style-type: none"> <li>• None found regarding: Live Outcome/Action Step: "...will cook a healthy recipe" for 9/1 – 14, 2018. Action step is to be completed 1 time per week.</li> </ul> <p>Individual #7</p> <ul style="list-style-type: none"> <li>• According to the Live Outcome; Action Step for "...will research new recipes is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/9 – 14, 2018.</li> </ul>		
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<p>essential to ensuring the health and safety of the person during the provision of the service.</p> <p>17. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable.</p> <p>18. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>19. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</p> <p>20. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>21. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>22. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p>			
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Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	Standard Level Deficiency		
<p><b>7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:</b>  C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed.</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018  <b>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:</b> All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:  1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.  2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic</p>	<p>Based on record review, the Agency did not complete written status reports as required for 3 of 7 individuals receiving Living Care Arrangements and Community Inclusion.</p> <p><b>Supported Living Semi-Annual Reports:</b></p> <ul style="list-style-type: none"> <li>Individual #1 - None found for 1/2018 – 6/2018. (Term of ISP 1/1/2018 - 12/31/2018).</li> <li>Individual #5 - Report not completed 14 days prior to the Annual ISP meeting. (Semi-Annual Report 11/1/2017 - 7/19/2018; Date Completed: 7/19/2018; ISP meeting held on 7/26/2018).</li> </ul> <p><b>Family Living Semi- Annual Reports:</b></p> <ul style="list-style-type: none"> <li>Individual #3 - None found for 5/2017 - 10/2017 and 11/2017 - 1/2018 (Term of ISP 5/1/2017 - 4/30/2018). ISP meeting held on 1/31/2018).</li> </ul> <p><b>Customized Community Supports Semi-Annual Reports:</b></p> <ul style="list-style-type: none"> <li>Individual #1 - None found for 1/2018 – 6/2018. (Term of ISP 1/1/2018 - 12/31/2018).</li> <li>Individual #5 - None found for 5/2018 - 7/2018. (Term of ISP 11/1/2017 - 10/31/2018. ISP meeting held on 7/26/2018).</li> </ul> <p><b>Community Integrated Employment Services Semi-Annual Reports:</b></p> <ul style="list-style-type: none"> <li>Individual #1 - None found for 1/2018 - 6/2018. (Term of ISP 1/1/2018 - 12/31/2018).</li> </ul>	<p><b>Provider:</b>  State your Plan of Correction for the deficiencies cited in this tag here (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p><b>Provider:</b>  Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (<i>What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

<p>records through the Therap web-based system using computers or mobile devices is acceptable.</p> <p>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</p> <p>5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>7. All records pertaining to JCMs must be retained permanently and must be made available to DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p><b>Chapter 19: Provider Reporting Requirements:</b>  <b>19.5 Semi-Annual Reporting:</b> The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDS for QA activities.  Semi-annual reports are required as follows:  1. DD Waiver Provider Agencies, except AT, EMSP, Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports.  2. A Respite Provider Agency must submit a semi-annual progress report to the CM that describes</p>			
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<p>progress on the Action Plan(s) and Desired Outcome(s) when Respite is the only service included in the ISP other than Case Management for an adult age 21 or older.</p> <p>3. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days).</p> <p>4. The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting.</p> <p>5. Semi-annual reports must contain at a minimum written documentation of:</p> <ul style="list-style-type: none"> <li>a. the name of the person and date on each page;</li> <li>b. the timeframe that the report covers;</li> <li>c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering;</li> <li>d. a description of progress towards Desired Outcomes in the ISP related to the service provided;</li> <li>e. a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing);</li> <li>f. significant changes in routine or staffing if applicable;</li> <li>g. unusual or significant life events, including significant change of health or behavioral health condition;</li> <li>h. the signature of the agency staff responsible for preparing the report; and</li> <li>i. any other required elements by service type that are detailed in these standards.</li> </ul>			
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<p>documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>6. The current Client File Matrix found in <u>Appendix A Client File Matrix</u> details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p><b>Chapter 19: Provider Reporting</b>  <b>Requirements 19.5 Semi-Annual Reporting:</b>  The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDSD for QA activities.</p> <p>Semi-annual reports are required as follows:</p> <p>5. Semi-annual reports must contain at a minimum written documentation of:</p> <ol style="list-style-type: none"> <li>a. the name of the person and date on each page;</li> <li>b. the timeframe that the report covers;</li> <li>c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering;</li> <li>d. a description of progress towards Desired Outcomes in the ISP related to the service provided;</li> <li>e. a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing);</li> <li>f. significant changes in routine or staffing if applicable;</li> </ol>			
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<p>g. unusual or significant life events, including significant change of health or behavioral health condition;</p> <p>h. the signature of the agency staff responsible for preparing the report; and</p> <p>i. any other required elements by service type that are detailed in these standards.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>CHAPTER 11 (FL) 3. Agency Requirements:</b></p> <p><b>E. Living Supports- Family Living Service Provider Agency Reporting Requirements:</b></p> <p><b>1. Semi-Annual Reports:</b> Family Living Provider must submit written semi-annual status reports to the individual's Case Manager and other IDT Members no later than one hundred ninety (190) calendar days after the ISP effective date. When reports are developed in any other language than English, it is the responsibility of the provider to translate the reports into English. The semi-annual reports must contain the following written documentation:</p> <p>a. Name of individual and date on each page;</p> <p>b. Timely completion of relevant activities from ISP Action Plans;</p> <p>c. Progress towards desired outcomes in the ISP accomplished during the past six months;</p> <p>d. Significant changes in routine or staffing;</p> <p>e. Unusual or significant life events, including significant change of health condition;</p> <p>f. Data reports as determined by IDT members; and</p> <p>g. Signature of the agency staff responsible for preparing the reports.</p>			
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<p>related to a PCA and Career Development Plan:</p> <p>5. A person-centered assessment should contain, at a minimum:</p> <ol style="list-style-type: none"> <li>a. information about the person's background and status;</li> <li>b. the person's strengths and interests;</li> <li>c. conditions for success to integrate into the community, including conditions for job success (for those who are working or wish to work); and</li> <li>d. support needs for the individual.</li> </ol> <p>6. The agency must have documented evidence that the person, guardian, and family as applicable were involved in the person-centered assessment.</p> <p>7. Timelines for completion: The initial PCA must be completed within the first 90 calendar days of the person receiving services. Thereafter, the Provider Agency must ensure that the PCA is reviewed and updated annually. An entirely new PCA must be completed every five years. If there is a significant change in a person's circumstance, a new PCA may be required because the information in the PCA may no longer be relevant. A significant change may include but is not limited to: losing a job, changing a residence or provider, and/or moving to a new region of the state.</p> <p>8. If a person is receiving more than one type of service from the same provider, one PCA with information about each service is acceptable.</p> <p>9. Changes to an updated PCA should be signed and dated to demonstrate that the assessment was reviewed.</p> <p>10. A career development plan is developed by the CIE provider and can be a separate document or be added as an addendum to a PCA. The career development plan should have specific action steps that identify who does what and by when.</p> <p><b>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records</b>  Requirements: All DD Waiver Provider Agencies</p>			
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<p>are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.</p> <p>DD Waiver Provider Agencies are required to adhere to the following:</p> <p>30. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.</p>			
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<p>service delivery, as well as data tracking only for the services provided by their agency.</p> <p>6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>7. All records pertaining to JCMs must be retained permanently and must be made available to DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p><b>20.5.3 Health Passport and Physician Consultation Form:</b> All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form. The Physician Consultation form contains a list of all current medications. Requirements for the Health Passport and Physician Consultation form are:</p> <p>2. The Primary and Secondary Provider Agencies must ensure that a current copy of the Health Passport and Physician Consultation forms are printed and available at all service delivery sites. Both forms must be reprinted and placed at all service delivery sites each time the e-CHAT is updated for any reason and whenever there is a change to contact information contained in the IDF.</p> <p><b>Chapter 13: Nursing Services:</b>  <b>13.2.9 Healthcare Plans (HCP):</b></p>			
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<p>1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans.</p> <p>2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary</p> <p><b>13.2.10 Medical Emergency Response Plan (MERP):</b></p> <p>1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP.</p> <p>2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>CHAPTER 11 (FL) 3. Agency Requirements</b></p> <p><b>C. Residence Case File:</b> The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.</p>			
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<p>documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>CHAPTER 11 (FL) 3. Agency Requirements</b></p> <p>C. Residence Case File: The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.</p>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<b>Service Domain: Qualified Providers</b> - 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.			
<b>Tag # 1A20 Direct Support Personnel Training</b>	<b>Condition of Participation Level Deficiency</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 17: Training Requirements:</b> The purpose of this chapter is to outline requirements for completing, reporting and documenting DDSD training requirements for DD Waiver Provider Agencies as well as requirements for certified trainers or mentors of DDSD Core curriculum training.</p> <p><b>17.1 Training Requirements for Direct Support Personnel and Direct Support Supervisors:</b> Direct Support Personnel (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports.</p> <ol style="list-style-type: none"> <li>1. DSP/DSS must successfully: <ol style="list-style-type: none"> <li>a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in 17.10 Individual-Specific Training below.</li> <li>b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14</li> <li>c. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements</li> <li>d. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines.</li> <li>e. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals).</li> </ol> </li> </ol>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 9 of 39 Direct Support Personnel.</p> <p>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <p><b>First Aid:</b></p> <ul style="list-style-type: none"> <li>• Expired (#505, 509, 520, 535)</li> </ul> <p><b>CPR:</b></p> <ul style="list-style-type: none"> <li>• Expired (#505, 509, 520, 535)</li> </ul> <p><b>Assisting with Medication Delivery:</b></p> <ul style="list-style-type: none"> <li>• Expired (#507, 510, 523, 531, 532)</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

<p>f. Become certified in a DDS-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using EPR. Agency DSP and DSS shall maintain certification in a DDS-approved system if any person they support has a BCIP that includes the use of EPR.</p> <p>g. Complete and maintain certification in a DDS-approved medication course if required to assist with medication delivery.</p> <p>h. Complete training regarding the HIPAA.</p> <p>2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDS required core trainings and be on shift with a DSP who has completed the relevant IST.</p> <p><b>17.1.2 Training Requirements for Service Coordinators (SC):</b> Service Coordinators (SCs) refer to staff at agencies providing the following services: Supported Living, Family Living, Customized In-home Supports, Intensive Medical Living, Customized Community Supports, Community Integrated Employment, and Crisis Supports.</p> <p>1. A SC must successfully:</p> <p>a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported, and as outlined in the 17.10 Individual-Specific Training below.</p> <p>b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14.</p> <p>c. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.</p> <p>d. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines.</p> <p>e. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals).</p> <p>f. Become certified in a DDS-approved system</p>			
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<p>of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using emergency physical restraint. Agency SC shall maintain certification in a DDS-approved system if a person they support has a Behavioral Crisis Intervention Plan that includes the use of emergency physical restraint.</p> <p>g. Complete and maintain certification in AWMD if required to assist with medications.</p> <p>h. Complete training regarding the HIPAA.</p> <p>2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDS required core trainings.</p>			
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<p>of birth, social security number, and other appropriate identifying information required by the registry.</p> <p><b>D. 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><b>E. 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><b>F. 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>			
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<p>the use of EPR.</p> <p>g. Complete and maintain certification in a DDS-approved medication course if required to assist with medication delivery.</p> <p>h. Complete training regarding the HIPAA.</p> <p>2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDS required core trainings and be on shift with a DSP who has completed the relevant IST.</p> <p><b>17.10 Individual-Specific Training:</b> The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDS training levels of awareness, knowledge, and skill.</p> <p>Reaching an <b>awareness level</b> may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness.</p> <p>Reaching a <b>knowledge level</b> may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence.</p> <p>Reaching a <b>skill level</b> involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained</p>			
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<p>and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported.</p> <ol style="list-style-type: none"> <li>1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends.</li> <li>2. IST for therapy-related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher.</li> <li>3. The competency level of the training is based on the IST section of the ISP.</li> <li>4. The person should be present for and involved in IST whenever possible.</li> <li>5. Provider Agencies are responsible for tracking of IST requirements.</li> <li>6. Provider Agencies must arrange and ensure that DSP's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings.</li> <li>7. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their</li> </ol>			
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<p>curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan.</p> <p><b>17.10.1 IST Training Rosters:</b> IST Training Rosters are required for all IST trainings:</p> <ol style="list-style-type: none"> <li>1. IST Training Rosters must include: <ol style="list-style-type: none"> <li>a. the name of the person receiving DD Waiver services;</li> <li>b. the date of the training;</li> <li>c. IST topic for the training;</li> <li>d. the signature of each trainee;</li> <li>e. the role of each trainee (e.g., CIHS staff, CIE staff, family, etc.); and</li> <li>f. the signature and title or role of the trainer.</li> </ol> </li> <li>2. A competency based training roster (required for CARMPs) includes all information above but also includes the level of training (awareness, knowledge, or skilled) the trainee has attained. (See Chapter 5.5 Aspiration Risk Management for more details about CARMPs.)</li> <li>3. A copy of the training roster is submitted to the agency employing the staff trained within seven calendar days of the training date. The original is retained by the trainer.</li> </ol>			
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<p>Reporting (GER), requirements. There are two important changes related to medication error reporting:</p> <ol style="list-style-type: none"> <li>1. Effective immediately, DDS requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau.</li> <li>2. No alternative methods for reporting are permitted.</li> </ol> <p><b>The following events need to be reported in the Therap GER:</b></p> <ul style="list-style-type: none"> <li>- Emergency Room/Urgent Care/Emergency Medical Services</li> <li>- Falls Without Injury</li> <li>- Injury (including Falls, Choking, Skin Breakdown and Infection)</li> <li>- Law Enforcement Use</li> <li>- Medication Errors</li> <li>- Medication Documentation Errors</li> <li>- Missing Person/Elopement</li> <li>- Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission</li> <li>- PRN Psychotropic Medication</li> <li>- Restraint Related to Behavior</li> <li>- Suicide Attempt or Threat</li> </ul> <p>Entry Guidance: Provider Agencies must complete the following sections of the GER with detailed information: profile information, event information, other event information, general information, notification, actions taken or planned, and the review follow up comments section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. <u>Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.</u></p>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<b>Service Domain: Health and Welfare</b> - 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.			
<b>Tag # 1A08.2 Administrative Case File: Healthcare Requirements &amp; Follow-up</b>	<b>Condition of Participation Level Deficiency</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 3 Safeguards: 3.1.1 Decision Consultation Process (DCP):</b> Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following:</p> <p>1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to:</p> <p>a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;</p> <p>b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy;</p> <p>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and</p> <p>d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review and interview, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 4 of 7 individuals receiving Living Care Arrangements and Community Inclusion.</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p><b>Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):</b></p> <p><b>Annual Physical:</b></p> <ul style="list-style-type: none"> <li>• Not Current (#5)</li> </ul> <p><b>Dental Exam:</b></p> <ul style="list-style-type: none"> <li>• Individual #6- As indicated by collateral documentation reviewed, exam was completed on 5/18/2018. Follow-up was to be completed in 3 months. No evidence of follow-up found.</li> </ul> <p><b>Vision Exam:</b></p> <ul style="list-style-type: none"> <li>• Individual #2 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

<p>2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting:</p> <p>a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation.</p> <p>b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation.</p> <p>c. Providers support the person/guardian to make an informed decision.</p> <p>d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.</p> <p><b>Chapter 20: Provider Documentation and Client Records:</b></p> <p><b>20.2 Client Records Requirements:</b> All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.</p> <p>DD Waiver Provider Agencies are required to adhere to the following:</p> <ol style="list-style-type: none"> <li>1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.</li> <li>2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic</li> </ol>	<ul style="list-style-type: none"> <li>• Individual #5 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</li> <li>• Individual #6 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</li> <li>• Individual #7 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</li> </ul> <p><b>PCP Follow-up:</b></p> <ul style="list-style-type: none"> <li>• Individual #7 - As indicated by collateral documentation reviewed, exam was completed on 2/7/2018. Follow-up was to be completed in 4 months. No evidence of follow-up found.</li> </ul>		
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<p>records through the Therap web based system using computers or mobile devices is acceptable.</p> <p>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</p> <p>5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>7. All records pertaining to JCMs must be retained permanently and must be made available to DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p><b>20.5.3 Health Passport and Physician Consultation Form:</b> All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form. The Physician Consultation form contains a list of all current medications.</p> <p><b>Chapter 10: Living Care Arrangements (LCA)</b>  <b>Living Supports-Supported Living: 10.3.9.6.1</b></p>			
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<p><b>Monitoring and Supervision</b></p> <p>4. Ensure and document the following:</p> <ul style="list-style-type: none"> <li>a. The person has a Primary Care Practitioner.</li> <li>b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist.</li> <li>c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist.</li> <li>d. The person receives a hearing test as recommended by a licensed audiologist.</li> <li>e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist.</li> </ul> <p>5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine).</p> <p><b>10.3.10.1 Living Care Arrangements (LCA) Living Supports-IMLS:</b></p> <p><b>10.3.10.2 General Requirements:</b> 9 . Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and annual dental checkup by a licensed dentist).</p> <p><b>Chapter 13 Nursing Services: 13.2.3 General Requirements:</b></p> <p>1. Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>Chapter 6 (CCS) 3. Agency Requirements:</b></p> <p>G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to</p>			
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<p>comply with the DDSD Individual Case File Matrix policy.</p> <p><b>Chapter 7 (CIHS) 3. Agency Requirements:</b>  E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p><b>Chapter 11 (FL) 3. Agency Requirements:</b>  D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p>DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012</p> <p><b>III. Requirement Amendments(s) or Clarifications:</b></p> <p>A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.</p> <p>H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.</p>			
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<p>d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials;</p> <p>e. Documentation of refused, missed, or held medications or treatments;</p> <p>f. Documentation of any allergic reaction that occurred due to medication or treatments; and</p> <p>g. For PRN medications or treatments:</p> <p>i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period;</p> <p>ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and</p> <p>iii. documentation of the effectiveness of the PRN medication or treatment.</p> <p><b>Chapter 10 Living Care Arrangements</b>  10.3.4 Medication Assessment and Delivery:  Living Supports Provider Agencies must support and comply with:</p> <ol style="list-style-type: none"> <li>1. the processes identified in the DDSD AWMD training;</li> <li>2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services;</li> <li>3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and</li> <li>4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).</li> </ol>			
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<p>d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials;</p> <p>e. Documentation of refused, missed, or held medications or treatments;</p> <p>f. Documentation of any allergic reaction that occurred due to medication or treatments; and</p> <p>g. For PRN medications or treatments:</p> <p>i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period;</p> <p>ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and</p> <p>iii. documentation of the effectiveness of the PRN medication or treatment.</p> <p><b>Chapter 10 Living Care Arrangements</b>  <b>10.3.4 Medication Assessment and Delivery:</b>  Living Supports Provider Agencies must support and comply with:</p> <ol style="list-style-type: none"> <li>1. the processes identified in the DDSD AWMD training;</li> <li>2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services;</li> <li>3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and</li> <li>4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).</li> </ol>			
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Tag # 1A09.2 Medication Delivery - Nurse Approval for PRN Medication	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 13 Nursing Services:</b></p> <p><b>13.2.12 Medication Delivery:</b> Nurses are required to:</p> <ol style="list-style-type: none"> <li>1. Be aware of the New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.</li> <li>2. Communicate with the Primary Care Practitioner and relevant specialists regarding medications and any concerns with medications or side effects.</li> <li>3. Educate the person, guardian, family, and IDT regarding the use and implications of medications as needed.</li> <li>4. Administer medications when required, such as intravenous medications; other specific injections; via NG tube; non-premixed nebulizer treatments or new prescriptions that have an ordered assessment.</li> <li>5. Monitor the MAR or treatment records at least monthly for accuracy, PRN use and errors.</li> <li>6. Respond to calls requesting delivery of PRNs from AWMD trained DSP and non-related (surrogate or host) Family Living Provider Agencies.</li> <li>7. Assure that orders for PRN medications or treatments have: <ol style="list-style-type: none"> <li>a. clear instructions for use;</li> <li>b. observable signs/symptoms or circumstances in which the medication is to be used or withheld; and</li> <li>c. documentation of the response to and effectiveness of the PRN medication administered.</li> </ol> </li> <li>8. Monitor the person's response to the use of routine or PRN pain medication and contact the prescriber as needed regarding its effectiveness.</li> <li>9. Assure clear documentation when PRN medications are used, to include:</li> </ol>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not maintain documentation of PRN usage as required by standard for 2 of 7 Individuals.</p> <p>Individual #6 September 2018 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following:</p> <ul style="list-style-type: none"> <li>• Pseudoeph Bromphen DM 30-2-10mg/5ml Syp Acel - PRN - 9/8- 17, 2018 (given 1 time daily)</li> </ul> <p>Individual #7 September 2018 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Acetaminophen 500mg - PRN - 9/18 (given 1 time).</li> <li>• Azithromycin 250mg - PRN - 9/7 (given 2 times) and 9/8, 9, 11 (given 1 time daily).</li> <li>• Ibuprofen 600mg - PRN - 9/7 - 10 (given 1 time daily).</li> <li>• Albuterol Sul 2.5mg/3ml Sol - PRN - 9/7, 13 (given 1 time); 9/9, 12 (given 2 times); 9/8, 11 (given 3 times).</li> </ul>	<p><b>Provider:</b> <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p><b>Provider:</b> <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (<i>What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

<p>a. DSP contact with nurse prior to assisting with medication.</p> <p>i. The only exception to prior consultation with the agency nurse is to administer selected emergency medications as listed on the Publications section of the DOH-DDSD -Clinical Services Website  <a href="https://nmhealth.org/about/ddsd/pgsv/clinical/">https://nmhealth.org/about/ddsd/pgsv/clinical/</a>.</p> <p>b. Nursing instructions for use of the medication.</p> <p>c. Nursing follow-up on the results of the PRN use.</p> <p>d. When the nurse administers the PRN medication, the reasons why the medications were given and the person's response to the medication.</p>			
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<p>office files, the delivery site, or with DSP while providing services in the community.</p> <p>7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p><b>Chapter 3 Safeguards: 3.1.1 Decision Consultation Process (DCP):</b> Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following:</p> <ol style="list-style-type: none"> <li>1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: <ol style="list-style-type: none"> <li>a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;</li> <li>b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy;</li> <li>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and</li> <li>d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.</li> </ol> </li> <li>2. When the person/guardian disagrees with a</li> </ol>	<p><b>GERD</b></p> <ul style="list-style-type: none"> <li>• Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a current plan found.</li> </ul> <p><b>Seizures</b></p> <ul style="list-style-type: none"> <li>• Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a current plan found.</li> </ul> <p><b>Medical Emergency Response Plans (MERP): Aspiration</b></p> <ul style="list-style-type: none"> <li>• Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a current plan found.</li> </ul> <p><b>Asthma:</b></p> <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. No evidence of a plan found.</li> </ul> <p><b>Seizures</b></p> <ul style="list-style-type: none"> <li>• Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a current plan found.</li> </ul>		
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<p>recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting:</p> <p>a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation.</p> <p>b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation.</p> <p>c. Providers support the person/guardian to make an informed decision.</p> <p>d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.</p> <p><b>Chapter 13 Nursing Services:</b>  <b>13.2.5 Electronic Nursing Assessment and Planning Process:</b> The nursing assessment process includes several DDSD mandated tools: the electronic Comprehensive Nursing Assessment Tool (e-CHAT), the Aspiration Risk Screening Tool (ARST) and the Medication Administration Assessment Tool (MAAT) . This process includes developing and training Health Care Plans and Medical Emergency Response Plans. The following hierarchy is based on budgeted services and is used to identify which Provider Agency nurse has primary responsibility for completion of the nursing assessment process and related subsequent planning and training. Additional communication and collaboration for planning specific to CCS or CIE services may be needed.  The hierarchy for Nursing Assessment and Planning responsibilities is:  1. Living Supports: Supported Living, IMLS or Family Living via ANS;</p>			
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<p>2. Customized Community Supports- Group; and  3. Adult Nursing Services (ANS):  a. for persons in Community Inclusion with health-related needs; or  b. if no residential services are budgeted but assessment is desired and health needs may exist.</p> <p><b>13.2.6 The Electronic Comprehensive Health Assessment Tool (e-CHAT)</b>  1. The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person.  2. The nurse must see the person face-to-face to complete the nursing assessment. Additional information may be gathered from members of the IDT and other sources.  3. An e-CHAT is required for persons in FL, SL, IMLS, or CCS-Group. All other DD Waiver recipients may obtain an e-CHAT if needed or desired by adding ANS hours for assessment and consultation to their budget.  4. When completing the e-CHAT, the nurse is required to review and update the electronic record and consider the diagnoses, medications, treatments, and overall status of the person. Discussion with others may be needed to obtain critical information.  5. The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections.</p> <p><b>13.2.7 Aspiration Risk Management Screening Tool (ARST)</b></p> <p><b>13.2.8 Medication Administration Assessment Tool (MAAT):</b>  1. A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting.  2. After completion of the MAAT, the nurse will present recommendations regarding the level of assistance with medication delivery (AWMD) to the IDT. A copy of the MAAT will be sent to all the team members two weeks before the annual ISP</p>			
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<p>meeting and the original MAAT will be retained in the Provider Agency records.</p> <p>3. Decisions about medication delivery are made by the IDT to promote a person's maximum independence and community integration. The IDT will reach consensus regarding which criteria the person meets, as indicated by the results of the MAAT and the nursing recommendations, and the decision is documented this in the ISP.</p> <p><b>13.2.9 Healthcare Plans (HCP):</b></p> <p>1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans.</p> <p>2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs plans that the nurse determines are warranted.</p> <p><b>13.2.10 Medical Emergency Response Plan (MERP):</b></p> <p>1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or</p>			
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<p>other conditions also warrant a MERP.  2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.</p> <p><b>Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and Physician Consultation Form:</b> All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>Chapter 6 (CCS) 2. Service Requirements. E.</b> The agency nurse(s) for Customized Community Supports providers must provide the following services: 1. Implementation of pertinent PCP orders; ongoing oversight and monitoring of the individual's health status and medically related supports when receiving this service;</p> <p><b>3. Agency Requirements: Consumer Records Policy:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p><b>Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy:</b> All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p><b>Chapter 11 (FL) 3. Agency Requirements:</b></p>			
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<p><b>D. Consumer Records Policy:</b> All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</p> <p><b>I. Health Care Requirements for Family Living:</b></p> <p><b>5.</b> A nurse employed or contracted by the Family Living Supports provider must complete the e-CHAT, the Aspiration Risk Screening Tool, (ARST), and the Medication Administration Assessment Tool (MAAT) and any other assessments deemed appropriate on at least an annual basis for each individual served, upon significant change of clinical condition and upon return from any hospitalizations. In addition, the MAAT must be updated for any significant change of medication regime, change of route that requires delivery by licensed or certified staff, or when an individual has completed training designed to improve their skills to support self-administration.</p> <p>a. For newly-allocated or admitted individuals, assessments are required to be completed within three (3) business days of admission or two (2) weeks following the initial ISP meeting, whichever comes first.</p> <p>b. For individuals already in services, the required assessments are to be completed no more than forty-five (45) calendar days and at least fourteen (14) calendar days prior to the annual ISP meeting.</p> <p>c. Assessments must be updated within three (3) business days following any significant change of clinical condition and within three (3) business days following return from hospitalization.</p> <p>d. Other nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members;</p>			
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<p>objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p>e. Develop any urgently needed interim Healthcare Plans or MERPs per DDSD policy pending authorization of ongoing Adult Nursing services as indicated by health status and individual/guardian choice.</p>			
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<p>obligation to contribute to the planning process, always focusing on how to best support the person.</p> <p><b>Chapter 3 Safeguards: 3.3.1 HRC Procedural Requirements:</b></p> <ol style="list-style-type: none"> <li>1. An invitation to participate in the HRC meeting of a rights restriction review will be given to the person (regardless of verbal or cognitive ability), his/her guardian, and/or a family member (if desired by the person), and the Behavior Support Consultant (BSC) at least 10 working days prior to the meeting (except for in emergency situations). If the person (and/or the guardian) does not wish to attend, his/her stated preferences may be brought to the meeting by someone whom the person chooses as his/her representative.</li> <li>2. The Provider Agencies that are seeking to temporarily limit the person's right(s) (e.g., Living Supports, Community Inclusion, or BSC) are required to support the person's informed consent regarding the rights restriction, as well as their timely participation in the review.</li> <li>3. The plan's author, designated staff (e.g., agency service coordinator) and/or the CM makes a written or oral presentation to the HRC.</li> <li>4. The results of the HRC review are reported in writing to the person supported, the guardian, the BSC, the mental health or other specialized therapy provider, and the CM within three working days of the meeting.</li> <li>5. HRC committees are required to meet at least on a quarterly basis.</li> <li>6. A quorum to conduct an HRC meeting is at least three voting members eligible to vote in each situation and at least one must be a community member at large.</li> <li>7. HRC members who are directly involved in the services provided to the person must excuse themselves from voting in that situation.</li> </ol> <p>Each HRC is required to have a provision for emergency approval of rights restrictions based upon credible threats of harm against self or</p>			
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<p>others that may arise between scheduled HRC meetings (e.g., locking up sharp knives after a serious attempt to injure self or others or a disclosure, with a credible plan, to seriously injure or kill someone). The confidential and HIPAA compliant emergency meeting may be via telephone, video or conference call, or secure email. Procedures may include an initial emergency phone meeting, and a subsequent follow-up emergency meeting in complex and/or ongoing situations.</p> <p>8. The HRC with primary responsibility for implementation of the rights restriction will record all meeting minutes on an individual basis, i.e., each meeting discussion for an individual will be recorded separately, and minutes of all meetings will be retained at the agency for at least six years from the final date of continuance of the restriction.</p> <p><b>3.3.3 HRC and Behavioral Support:</b> The HRC reviews temporary restrictions of rights that are related to medical issues or health and safety considerations such as decreased mobility (e.g., the use of bed rails due to risk of falling during the night while getting out of bed). However, other temporary restrictions may be implemented because of health and safety considerations arising from behavioral issues. Positive Behavioral Supports (PBS) are mandated and used when behavioral support is needed and desired by the person and/or the IDT. PBS emphasizes the acquisition and maintenance of positive skills (e.g. building healthy relationships) to increase the person's quality of life understanding that a natural reduction in other challenging behaviors will follow. At times, aversive interventions may be temporarily included as a part of a person's behavioral support (usually in the BCIP), and therefore, need to be reviewed prior to implementation as well as periodically while the restrictive intervention is in place. PBSPs not containing aversive interventions do not require</p>			
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<p>HRC review or approval. Plans (e.g., ISPs, PBSPs, BCIPs PPMPs, and/or RMPs) that contain any aversive interventions are submitted to the HRC in advance of a meeting, except in emergency situations.</p> <p><b>3.3.4 Interventions Requiring HRC Review and Approval:</b> HRCs must review prior to implementation, any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies, including but not limited to:</p> <ol style="list-style-type: none"> <li>1. response cost;</li> <li>2. restitution;</li> <li>3. emergency physical restraint (EPR);</li> <li>4. routine use of law enforcement as part of a BCIP;</li> <li>5. routine use of emergency hospitalization procedures as part of a BCIP;</li> <li>6. use of point systems;</li> <li>7. use of intense, highly structured, and specialized treatment strategies, including level systems with response cost or failure to earn components;</li> <li>8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons;</li> <li>9. use of PRN psychotropic medications;</li> <li>10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand);</li> <li>11. use of bed rails;</li> <li>12. use of a device and/or monitoring system through PST may impact the person's privacy or other rights; or</li> <li>13. use of any alarms to alert staff to a person's whereabouts.</li> </ol> <p><b>3.4 Emergency Physical Restraint (EPR):</b> Every person shall be free from the use of restrictive physical crisis intervention measures that are unnecessary. Provider Agencies who support people who may occasionally need intervention such as Emergency Physical Restraint (EPR) are required to institute procedures to maximize safety.</p>			
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<p><b>3.4.5 Human Rights Committee:</b> The HRC reviews use of EPR. The BCIP may not be implemented without HRC review and approval whenever EPR or other restrictive measure(s) are included. Provider Agencies with an HRC are required to ensure that the HRCs:</p> <ol style="list-style-type: none"> <li>1. participate in training regarding required constitution and oversight activities for HRCs;</li> <li>2. review any BCIP, that include the use of EPR;</li> <li>3. occur at least annually, occur in any quarter where EPR is used, and occur whenever any change to the BCIP is considered;</li> <li>4. maintain HRC minutes approving or disallowing the use of EPR as written in a BCIP; and</li> <li>5. maintain HRC minutes of meetings reviewing the implementation of the BCIP when EPR is used.</li> </ol>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<b>Service Domain: Medicaid Billing/Reimbursement</b> - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.			
<b>Tag # IS30 Customized Community Supports Reimbursement</b>	<b>Standard Level Deficiency</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:</b> DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> <li>1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing.</li> <li>2. Comprehensive documentation of direct service delivery must include, at a minimum: <ol style="list-style-type: none"> <li>a. the agency name;</li> <li>b. the name of the recipient of the service;</li> <li>c. the location of the service;</li> <li>d. the date of the service;</li> <li>e. the type of service;</li> <li>f. the start and end times of the service;</li> <li>g. the signature and title of each staff member who documents their time; and</li> <li>h. the nature of services.</li> </ol> </li> <li>3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer.</li> <li>4. A Provider Agency that 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:</li> </ol>	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 3 of 6 individuals.</p> <p>Individual #1 June 2018</p> <ul style="list-style-type: none"> <li>• The Agency billed 44 units of Customized Community Supports (Individual) (H2021 HB U1) from 6/4/2018 through 6/7/2018. Documentation received accounted for 24 units</li> <li>• The Agency billed 104 units of Customized Community Supports (Group) (T2021 HB U8) from 6/11/2018 through 6/15/2018. Documentation received accounted for 96 units.</li> </ul> <p>August 2018</p> <ul style="list-style-type: none"> <li>• The Agency billed 20 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/13/2018 through 8/17/2018. Documentation received accounted for 16 units.</li> </ul> <p>Individual #5 June 2018</p> <ul style="list-style-type: none"> <li>• The Agency billed 14 units of Customized Community Supports (Individual) (H2021 HB U1) on 6/5/2018. Documentation received accounted for 4 units.</li> <li>• The Agency billed 40 units of Customized Community Supports (Individual) (HB2021 HB</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (<i>What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

<p>a. treatment or care of any eligible recipient;  b. services or goods provided to any eligible recipient;  c. amounts paid by MAD on behalf of any eligible recipient; and  d. any records required by MAD for the administration of Medicaid.</p> <p><b>21.9 Billable Units:</b> The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units.</p> <p><b>21.9.1 Requirements for Daily Units:</b> For services billed in daily units, Provider Agencies must adhere to the following:  1. A day is considered 24 hours from midnight to midnight.  2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period.  3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months.  4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows:  a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%).  b. The receiving Provider Agency bills the remaining days up to 340 for the ISP year.</p> <p><b>21.9.2 Requirements for Monthly Units:</b> For services billed in monthly units, a Provider Agency must adhere to the following:  1. A month is considered a period of 30 calendar days.</p>	<p>U1) on 6/17/2018. Documentation received accounted for 22 units.</p> <p>Individual #7  June 2018</p> <ul style="list-style-type: none"> <li>• The Agency billed 60 units of Customized Community Supports (Individual) (H2021 HB U1) from 6/11/2018 through 6/15/2018. Documentation received accounted for 48 units.</li> <li>• The Agency billed 68 units of Customized Community Supports (Individual) (H2021 HB U1) from 6/18/2018 through 6/22/2018. Documentation received accounted for 52 units.</li> <li>• The Agency billed 80 units of Customized Community Supports (Individual) (H2021 HB U1) from 6/25/2018 through 6/29/2018. Documentation received accounted for 60 units.</li> </ul> <p>July 2018</p> <ul style="list-style-type: none"> <li>• The Agency billed 80 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/2/2018 through 7/6/2018. Documentation received accounted for 72 units.</li> <li>• The Agency billed 80 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/9/2018 through 7/13/2018. Documentation received accounted for 64 units.</li> <li>• The Agency billed 80 units of Customized Community Supports (Individual) (H2021 HB U1) from 7/16/2018 through 7/20/2018. Documentation received accounted for 64 units.</li> </ul>		
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<p>2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed.</p> <p>3. Monthly units can be prorated by a half unit.</p> <p>4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit.</p> <p><b>21.9.3 Requirements for 15-minute and hourly units:</b> For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:</p> <p>1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2.</p> <p>2. Services that last in their entirety less than eight minutes cannot be billed.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p><b>CHAPTER 6 (CCS) 4. REIMBURSEMENT</b></p> <p><b>A. Required Records:</b> Customized Community Supports Services Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. Customized Community Supports Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.</p> <p><b>B. Billable Unit:</b></p> <p>1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute</p>			
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<p>unit.</p> <p>2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit.</p> <p>3. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group assignment.</p> <p>4. The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Customized Community Supports without prior approval from DDSD.</p> <p>5. The billable unit for Individual Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit.</p> <p>6. The billable unit for Fiscal Management for Adult Education is one dollar per unit including a 10% administrative processing fee.</p> <p>7. The billable units for Adult Nursing Services are addressed in the Adult Nursing Services Chapter.</p> <p><b>C. Billable Activities: All DSP activities that are:</b></p> <p>a. Provided face to face with the individual;</p> <p>b. Described in the individual's approved ISP;</p> <p>c. Provided in accordance with the Scope of Services; and</p> <p>d. Activities included in billable services, activities or situations.</p>			
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<p>eligible recipient; and</p> <p>d. any records required by MAD for the administration of Medicaid.</p> <p><b>21.9 Billable Units:</b> The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units.</p> <p><b>21.9.1 Requirements for Daily Units:</b> For services billed in daily units, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> <li>1. A day is considered 24 hours from midnight to midnight.</li> <li>2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period.</li> <li>3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months.</li> <li>4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows: <ol style="list-style-type: none"> <li>a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%).</li> <li>b. The receiving Provider Agency bills the remaining days up to 340 for the ISP year.</li> </ol> </li> </ol> <p><b>21.9.2 Requirements for Monthly Units:</b> For services billed in monthly units, a Provider Agency must adhere to the following:</p> <ol style="list-style-type: none"> <li>1. A month is considered a period of 30 calendar days.</li> <li>2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed.</li> <li>3. Monthly units can be prorated by a half unit.</li> <li>4. Agency transfers not occurring at the beginning of the 30-day interval are required to</li> </ol>			
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Date: March 22, 2019

To: Sylvia D. Torres, Executive Director  
Provider: Milagro De Vida Community Service, LLC  
Address: 1591 E. Lohman, Suite A  
City, State, Zip: Las Cruces, New Mexico 88001

E-mail Address: [sylviatorres@mdv-nm.com](mailto:sylviatorres@mdv-nm.com)

Region: Southwest  
Survey Date: September 14 – 20, 2018  
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012 & 2018:** Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports, Community Integrated Employment Services

Survey Type: Routine

Dear Sylvia D. Torres;

The Division of Health Improvement Quality Management Bureau received and reviewed the documents you submitted for your Plan of Correction. Your Plan of Correction is not closed.

**Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.**

The Quality Management Bureau will need to conduct a verification survey to ensure previously cited deficiencies have been corrected and that systemic Quality Improvement and Quality Assurance processes have been effective at sustaining corrections.

If the Verification survey determines survey deficiencies have been corrected and corrective measures have effectively maintained compliance with DDW Standards, your Plan of Correction will be considered for closure.

If the Verification survey identifies repeat deficiencies, the Plan of Correction process will continue and your case may be referred to the Internal Review Committee for discussion of possible civil monetary penalties possible monetary fines and/or other sanctions.

Thank you for your cooperation with the Plan of Correction process.  
Sincerely,

*Amanda Castañeda*

Amanda Castañeda  
Health Program Manager/Plan of Correction Coordinator  
Quality Management Bureau/DHI

Q.19.1.DDW.27359557.3.RTN.07.19.081