

Date: January 17, 2020 (*Upheld by IRF on 2/20/2020*)

To: April Licon, Director/Owner
Provider: Quality Life Services, LLC
Address: 1051 N. Solano Drive
State/Zip: Las Cruces, New Mexico 88001

E-mail Address: April.licon@qlsnm.com

CC: Sally Chavez, Director
Address: 1051 N. Solano Drive
State/Zip: Las Cruces, New Mexico 88001

E-mail Address: Sally.chavez@qlsnm.com

Region: Southwest
Survey Date: December 6 -11, 2019

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2018:** Supported Living; Family Living; Customized In-Home Supports; Customized Community Supports

Survey Type: Routine

Team Leader: Caitlin Wall, BA, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Amanda Castaneda, MPA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Verna Newman-Sikes, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Monica de Herrera Pardo, LBSW, MCJ, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Beverly Estrada, AND, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. April Licon;

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:

DIVISION OF HEALTH IMPROVEMENT
5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
(505) 222-8623 • FAX: (505) 222-8661 • <https://nmhealth.org/about/dhi/>



Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags: This determination is based on noncompliance with one to five (1 – 5) 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.

The following tags are identified as Condition of Participation Level:

- Tag # 1A22 Agency Personnel Competency
- Tag # 1A25.1 Caregiver Criminal History Screening
- Tag # 1A05 General Requirements / Agency Policy and Procedure Requirements
- Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication

The following tags are identified as Standard Level:

- Tag # 1A08.1 Administrative and Residential Case File: Progress Notes
- 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 # 1A26 Consolidated On-line Registry Employee Abuse Registry
- Tag # 1A37 Individual Specific Training
- Tag # 1A43.1 General Events Reporting: Individual Reporting
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A09.0 Medication Delivery Routine Medication Administration
- Tag # 1A09.1 Medication Delivery PRN Medication Administration
- Tag # 1A33.1 Board of Pharmacy – License
- Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living)
- Tag # LS27 Family 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: Monica Valdez, Plan of Correction Coordinator
5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108**

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

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

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

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 mail to:

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

If you have questions and would like to speak with someone at HSD/OIG/PIU, please contact:

Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)
OR
Jennifer Goble (Jennifer.goble2@state.nm.us)

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:

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

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, *Monica Valdez* at 505-273-1930 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,

Caitlin Wall, BSW, BA

Caitlin Wall, BSW, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	December 6, 2019
Contact:	<u>Quality Life Services, LLC</u> Sally Chavez, Director April Licon, Director / Owner <u>DOH/DHI/QMB</u> Caitlin Wall, BA, BSW, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	December 9, 2019
Present:	<u>Quality Life Services, LLC</u> April Licon, Director / Owner Sally Chavez, Director Debbie Ortega, Registered Nurse Jennifer Padilla, Service Coordinator <u>DOH/DHI/QMB</u> Caitlin Wall, BA, BSW, Team Lead/Healthcare Surveyor Beverly Estrada, AND, Healthcare Surveyor Verna Newman-Sikes, AA, Healthcare Surveyor Monica de Herrera Pardo, LBSW, MCJ, Healthcare Surveyor
Exit Conference Date:	December 11, 2019
Present:	<u>Quality Life Services, LLC</u> April Licon, Director / Owner Sally Chavez, Director Debbie Ortega, Registered Nurse Jennifer Padilla, Service Coordinator <u>DOH/DHI/QMB</u> Caitlin Wall, BA, BSW, Team Lead/Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor Verna Newman-Sikes, AA, Healthcare Surveyor Monica de Herrera Pardo, LBSW, MCJ, Healthcare Surveyor <u>DDSD - SW Regional Office</u> Brandi Rede, Case Manager Coordinator
Administrative Locations Visited:	1
Total Sample Size:	7 0 - <i>Jackson</i> Class Members 7 - <i>Non-Jackson</i> Class Members 4 - Supported Living 2 - Family Living 1 - Customized In-Home Supports 6 - Customized Community Supports
Total Homes Visited	6
❖ Supported Living Homes Visited	4

❖ Family Living Homes Visited	2
Persons Served Records Reviewed	7
Persons Served Interviewed	3
Persons Served Observed	3 <i>(Three Individuals chose not to participate in the interview process)</i>
Persons Served Not Seen and/or Not Available	1
Direct Support Personnel Records Reviewed	48
Direct Support Personnel Interviewed	11
Service Coordinator Records Reviewed	3
Nurse Interview	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 DDSD 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 505-273-1930 or email at MonicaE.Valdez@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD 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, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@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 Monica Valdez, POC Coordinator in any of the following ways:
 - a. Electronically at MonicaE.Valdez@state.nm.us (**preferred method**)
 - b. Fax to 505-222-8661, or
 - c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “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

- **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 Coordination - Nurse Availability / Knowledge
- **1A31** – Client Rights/Human Rights
- **LS25.1** – Residential Reqts. (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 Bureau Chief **within 10 business days** of receipt of the final Report of Findings (**Note: No extensions are granted for the IRF**).
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, Valerie V. Valdez at valerie.valdez@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 total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level 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	
Total 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%	
"Non-Compliance"						17 or more Total Tags with 75 to 100% of the Individuals in the sample cited in any CoP Level tag.	Any Amount of Standard Level Tags and 6 or more Conditions of Participation Level Tags.
"Partial Compliance with Standard Level tags and Condition of Participation Level Tags"					Any Amount Standard Level Tags, plus 1 to 5 Conditions of Participation Level tags.		
"Partial Compliance with Standard Level tags"			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.			
"Compliance"	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: Quality Life Services, LLC - Southwest Region
Program: Developmental Disabilities Waiver
Service: 2018: Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports
Survey Type: Routine
Survey Date: December 6 – 11, 2019

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Service Plans: ISP Implementation – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.			
Tag # 1A08.1 Administrative and Residential Case File: Progress Notes (Upheld by IRF)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements: 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"> 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. 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. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, 	<p>Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 2 of 7 Individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found:</p> <p>Administrative Case File:</p> <p>Customized Community Services Notes/Daily Contact Logs:</p> <p>Individual #3</p> <ul style="list-style-type: none"> Review of progress notes indicate separate progress notes were not kept for Customized Community Support - Individual Services and Customized Community Support - Individual Intensive Behavioral Support services for 8/1/2019 - 10/31/2019. (Note: Document provided accounted for one service, with two staff signatures.) <p>Individual #6</p> <ul style="list-style-type: none"> Review of progress notes indicate separate progress notes were not kept for Customized Community Support - Individual Services and Customized Community Support - Individual Intensive Behavioral Support services for 8/1/2019 - 10/31/2019. (Note: Document 	<p>Provider: 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> </p> <p> </p> <p>Provider: 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> </p> <p> </p>	<p> </p> <p> </p>

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<p>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>	<p><i>provided accounted for one service, with two staff signatures.)</i></p> <p><i>(Note: Finding for Individual #3 & 6 upheld by IRF 2/20/2020).</i></p>		
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Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency) (Upheld by IRF)	Standard Level Deficiency		
<p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 4 of 7 individuals.</p> <p>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #4</p> <ul style="list-style-type: none"> • According to the Live Outcome; Action Step for "... will clean his room" 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 8/2019. • According to the Health/Other Outcome; Action Step for "... will attend sporting event" 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 8/2019 and 10/2019. <p>Individual #6</p> <ul style="list-style-type: none"> • According to the Live Outcome; Action Step for "Research meal ideas and purchase 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 8/2019. • According to the Live Outcome; Action Step for "Cook Meal" is to be completed 1 time per 	<p>Provider: 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>Provider: 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>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 6: Individual Service Plan (ISP) 6.8 ISP Implementation and Monitoring: 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>Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements: 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"> 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 	<p>week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2019.</p> <p>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #5</p> <ul style="list-style-type: none"> • According to the Live Outcome; Action Step for "... will help with household chores" 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 8/2019 – 10/2019. <p>Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #7</p> <ul style="list-style-type: none"> • According to the Live Outcome; Action Step for "... will research healthy dish and create a list" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2019 – 10/2019. • According to the Live Outcome; Action Step for "... will purchase items needed to prepare a healthy dish" 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 10/2019. • According to the Live Outcome; Action Step for "Prepare a dish" 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 10/2019. 		
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<p>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>	<p>Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #7</p> <ul style="list-style-type: none"> • According to the Fun Outcome; Action Step for "... will research support groups to attend based on relationships" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2019. <p><i>(Note: Finding for Individual #4, 6 and 7 upheld by IRF 2/20/2020).</i></p>		
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Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation) <i>(Upheld by IRF)</i>	Standard Level Deficiency		
<p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on residential record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 2 of 6 individuals.</p> <p>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #2</p> <ul style="list-style-type: none"> According to the Live Outcome; Action Step for "...plan date, menu, and invite family" 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 12/1 – 6, 2019. (Date of home visit: 12/9/2019) <p>Individual #5</p> <ul style="list-style-type: none"> None found regarding: Live Outcome/Action Step: "... will help with household chores" for 12/1 – 6, 2019. Action step is to be completed 1 time per week. (Date of home visit: 12/11/2019) <p><i>(Note: Finding for Individual #2 & 5 upheld by IRF 2/20/2020).</i></p>	<p>Provider: 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>Provider: 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>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 6: Individual Service Plan (ISP) 6.8 ISP Implementation and Monitoring: 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>Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements: 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 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</p>			
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<p>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>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>			
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Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements <i>(Upheld by IRF)</i>	Standard Level Deficiency		
<p>7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:</p> <p>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; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements: 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>Based on record review, the Agency did not complete written status reports as required for 2 of 7 individuals receiving Living Care Arrangements and Community Inclusion.</p> <p>Supported Living Semi-Annual Reports:</p> <ul style="list-style-type: none"> Individual #6 - Report not completed 14 days prior to the Annual ISP meeting. <i>(Term of ISP 8/1/2018 – 7/31/2019. Semi-Annual Report 1/28/2019 – 3/26/2019; Date Completed: 3/27/2019; ISP meeting held on 4/1/2019).</i> <p>Customized Community Supports Semi-Annual Reports</p> <ul style="list-style-type: none"> Individual #6 - Report not completed 14 days prior to the Annual ISP meeting. <i>(Term of ISP 8/1/2018 – 7/31/2019. Semi-Annual Report 1/28/2019 – 3/26/2019; Date Completed: 3/27/2019; ISP meeting held on 4/1/2019).</i> <p>Nursing Semi-Annual:</p> <ul style="list-style-type: none"> Individual #2 - Report not completed 14 days prior to the Annual ISP meeting. <i>(Term of ISP 8/1/2018 – 7/31/2019. Semi-Annual Report 10/1/2018 – 4/24/2019; Date Completed: 4/29/2019; ISP meeting held on 5/7/2019).</i> Additionally, report covered 10/1/2018 – 4/24/2019 <i>Per regulations reports must coincide with ISP term.</i> Individual #6 - Report not completed 14 days prior to the Annual ISP meeting. <i>(Term of ISP 8/1/2018 – 7/31/2019. Semi-Annual Report 1/28/2019 – 3/26/2019; Date Completed: 3/27/2019; ISP meeting held on 4/1/2019).</i> <p><i>(Note: Finding for Individual #2 upheld by IRF 2/20/2020).</i></p>	<p>Provider: 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>Provider: 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>DD Waiver Provider Agencies are required to adhere to the following:</p> <ol style="list-style-type: none"> 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 records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 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. 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. 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. 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. 			
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<p>Chapter 19: Provider Reporting Requirements 19.5 Semi-Annual Reporting:</p> <p>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.</p> <p>Semi-annual reports are required as follows:</p> <ol style="list-style-type: none"> 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 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. 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). 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. 5. Semi-annual reports must contain at a minimum written documentation of: <ol style="list-style-type: none"> a. the name of the person and date on each page; b. the timeframe that the report covers; c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering; 			
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<ul style="list-style-type: none"> d. a description of progress towards Desired Outcomes in the ISP related to the service provided; e. a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing); f. significant changes in routine or staffing if applicable; g. unusual or significant life events, including significant change of health or behavioral health condition; h. the signature of the agency staff responsible for preparing the report; and i. any other required elements by service type that are detailed in these standards. 			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
<p>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.</p>			
<p>Tag # 1A22 Agency Personnel Competency <i>(Upheld by IRF)</i></p>	<p>Condition of Participation Level Deficiency</p>		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 13: Nursing Services 13.2.11 Training and Implementation of Plans:</p> <p>1. RNs and LPNs are required to provide Individual Specific Training (IST) regarding HCPs and MERPs.</p> <p>2. The agency nurse is required to deliver and document training for DSP/DSS regarding the healthcare interventions/strategies and MERPs that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee as described in Chapter 17.10 Individual-Specific Training.</p> <p>Chapter 17: Training Requirement 17.10 Individual-Specific Training: 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 DDSD training levels of awareness, knowledge, and skill.</p> <p>Reaching an awareness level 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>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 interview, the Agency did not ensure training competencies were met for 2 of 11 Direct Support Personnel.</p> <p>When DSP were asked, if the Individual's had Health Care Plans, where could they be located and if they had been trained, the following was reported:</p> <ul style="list-style-type: none"> DSP #504 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Neuro (Devices and implants: cerebral shunt, baclofen pump, VNS) and Seizure Disorder. (Individual #2) <p>When DSP were asked, if the Individual's had Medical Emergency Response Plans and where could they be located, the following was reported:</p> <ul style="list-style-type: none"> DSP #504 stated, "No, she doesn't" As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Neuro (Devices and implants: cerebral shunt, baclofen pump, VNS) and Seizure Disorder. (Individual #2) 	<p>Provider: 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>Provider: 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>Reaching a knowledge level 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 skill level 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 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> <p>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.</p> <p>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.</p>	<p>When Direct Support Personnel were asked, what State Agency do you report suspected Abuse, Neglect or Exploitation, the following was reported:</p> <ul style="list-style-type: none"> DSP #506 stated, “I don’t remember the name. I have the folder in the house with the number.” Staff was not able to identify the State Agency as Division of Health Improvement. <p><i>(Note: Finding for DSP #504 & 506 upheld by IRF 2/20/2020).</i></p>		
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<p>3. The competency level of the training is based on the IST section of the ISP.</p> <p>4. The person should be present for and involved in IST whenever possible.</p> <p>5. Provider Agencies are responsible for tracking of IST requirements.</p> <p>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.</p> <p>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 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>			
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Tag # 1A25.1 Caregiver Criminal History Screening	Condition of Participation Level Deficiency		
<p>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:</p> <p>A. General: The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (Amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider] to impose appropriate administrative sanctions and penalties.</p> <p>B. Exception: A caregiver or hospital caregiver applying for employment or contracting services with a care provider within twelve (12) months of the caregiver's or hospital caregiver's most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested.</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, the Agency did not maintain documentation indicating Caregiver Criminal History Screening was completed as required for 1 of 51 Agency Personnel.</p> <p>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</p> <p>Direct Support Personnel (DSP):</p> <ul style="list-style-type: none"> • #533 – Date of hire 4/1/2019. 	<p>Provider: 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> </p> <p> </p> <p>Provider: 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> </p> <p> </p>	<p> </p> <p> </p>

<p>C. Conditional Employment: Applicants, caregivers, and hospital caregivers who have submitted all completed documents and paid all applicable fees for a nationwide and statewide criminal history screening may be deemed to have conditional supervised employment pending receipt of written notice given by the department as to whether the applicant, caregiver or hospital caregiver has a disqualifying conviction.</p> <p>F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</p> <p>G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules.</p> <p>(1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification.</p> <p>(2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes.</p>			
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<p>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</p> <p>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: A. homicide; B. trafficking, or trafficking in controlled substances; C. kidnapping, false imprisonment, aggravated assault or aggravated battery; D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; E. crimes involving adult abuse, neglect or financial exploitation; F. crimes involving child abuse or neglect; G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p>			
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Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry <i>(Upheld by IRF)</i>	Standard Level Deficiency		
<p>NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search</p>	<p>Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 4 of 51 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:</p> <p>Direct Support Personnel (DSP):</p> <ul style="list-style-type: none"> • #503 – Date of hire 7/15/2018, completed 7/16/2018. • #523 – Date of hire 10/24/2018, completed 11/19/2018. • #524 – Date of hire 6/13/2018, completed 10/16/2018. • #532 – Date of hire 11/24/2019, completed 12/3/2019. <p><i>(Note: Finding for DSP #503, 523, 524 upheld by IRF 2/20/2020).</i></p>	<p>Provider: 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> </p> <p> </p> <p>Provider: 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> </p> <p> </p>	<p> </p> <p> </p>

<p>the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.</p> <p>F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.</p>			
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Tag # 1A37 Individual Specific Training <i>(Upheld by IRF)</i>	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 17: Training Requirements: 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>17.1 Training Requirements for Direct Support Personnel and Direct Support Supervisors: 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> <p>1. DSP/DSS must successfully:</p> <ol style="list-style-type: none"> 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. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14 Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) 	<p>Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 1 of 51 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <p>Direct Support Personnel (DSP):</p> <ul style="list-style-type: none"> Individual Specific Training (#533) <p><i>(Note: Finding for DSP #533 upheld by IRF 2/20/2020).</i></p>	<p>Provider: 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> </p> <p> </p> <p>Provider: 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> </p> <p> </p>	

<p>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>17.10 Individual-Specific Training: 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 awareness level 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 knowledge level 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 skill level 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</p>			
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<p>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 and to provide additional coaching/feedback.</p> <p>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"> 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. 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. 3. The competency level of the training is based on the IST section of the ISP. 4. The person should be present for and involved in IST whenever possible. 5. Provider Agencies are responsible for tracking of IST requirements. 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 			
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<p>and notify the plan authors when new DSP are hired to arrange for trainings.</p> <p>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 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>17.10.1 IST Training Rosters: IST Training Rosters are required for all IST trainings:</p> <ol style="list-style-type: none"> 1. IST Training Rosters must include: <ol style="list-style-type: none"> a. the name of the person receiving DD Waiver services; b. the date of the training; c. IST topic for the training; d. the signature of each trainee; e. the role of each trainee (e.g., CIHS staff, CIE staff, family, etc.); and f. the signature and title or role of the trainer. 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.) 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. 			
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Tag # 1A43.1 General Events Reporting: Individual Reporting <i>(Upheld by IRF)</i>	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 19: Provider Reporting Requirements: 19.2 General Events Reporting (GER): The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows:</p> <ol style="list-style-type: none"> DD Waiver Provider Agencies approved to provide Customized In- Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use GER in the Therap system. DD Waiver Provider Agencies referenced above are responsible for entering specified information into the GER section of the secure website operated under contract by Therap according to the GER Reporting Requirements in Appendix B GER Requirements. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap. GER does not replace a Provider Agency's obligations to report ANE or other reportable incidents as described in Chapter 18: 	<p>Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 4 of 7 individuals.</p> <p>The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within the required timeframe:</p> <p>Individual #1</p> <ul style="list-style-type: none"> General Events Report (GER) indicates on 9/5/2019 the Individual was sitting on the bottom bleacher at a volleyball game. A ball flew into the left lower leg. (Injury). GER was approved 9/10/2019. General Events Report (GER) indicates on 10/7/2019 the Individual bumped left knee on the corner of the bathroom cabinet. (Injury). GER was approved 10/10/2019. General Events Report (GER) indicates on 10/25/2019 the Individual fell at the movie theater while receiving services with another agency. (Injury). GER was approved 11/3/2019. General Events Report (GER) indicates on 11/4/2019 the Individual bit self on the arm. (Injury). GER was approved 11/7/2019. <p>Individual #3</p> <ul style="list-style-type: none"> General Events Report (GER) indicates on 6/8/2019 the Individual refused to get out of the car and banged head. (PRN Psychotropic Use). GER was approved 6/20/2019. 	<p>Provider: 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>Provider: 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>Incident Management System.</p> <p>5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities.</p> <p>Appendix B GER Requirements: DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting:</p> <ol style="list-style-type: none"> 1. <i>Effective immediately</i>, DDSD 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. 2. No alternative methods for reporting are permitted. <p><u>The following events need to be reported in the Therap GER:</u></p> <ul style="list-style-type: none"> • Emergency Room/Urgent Care/Emergency Medical Services • Falls Without Injury • Injury (including Falls, Choking, Skin Breakdown and Infection) • Law Enforcement Use • Medication Errors • Medication Documentation Errors • Missing Person/Elopement • Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission • PRN Psychotropic Medication • Restraint Related to Behavior • Suicide Attempt or Threat <p><u>Entry Guidance:</u> Provider Agencies must complete the following sections of the GER with detailed information: profile information,</p>	<ul style="list-style-type: none"> • General Events Report (GER) indicates on 6/25/2019 the Individual was upset because day staff was leaving. Individual sat on the couch and picked at skin. (PRN Psychotropic Use). GER was approved 7/11/2019. • General Events Report (GER) indicates on 7/17/2019 the Individual fell onto knees while walking to throw the trash. (Injury). GER was approved 7/22/2019. • General Events Report (GER) indicates on 7/20/2019 the Individual got aggressive in the truck trying to open the door and pulled the wheel while staff was driving. (PRN Psychotropic Use). GER was approved 7/24/2019. • General Events Report (GER) indicates on 7/21/2019 the Individual was given a PRN for anxiety and bad behavior. (PRN Psychotropic Use). GER was approved 7/24/2019. • General Events Report (GER) indicates on 8/9/2019 the Individual got upset and banged head on the wall 3 times. (Injury). GER was approved 8/26/2019. • General Events Report (GER) indicates on 8/13/2019 the Individual threw self on the floor, and banged head against the window. (Injury). GER was approved 8/26/2019. • General Events Report (GER) indicates on 8/13/2019 the Individual swung at staff and banged head against the window. (Injury). GER was approved 8/26/2019. • General Events Report (GER) indicates on 8/23/2019 the Individual swung at staff and 		
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<p>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>	<p>fell onto knees. (Fall Without Injury). GER was approved 9/4/2019</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 8/24/2019 the Individual smeared feces on the wall and tried kissing staff on the hand. (PRN Psychotropic Use). GER was approved 9/4/2019. • General Events Report (GER) indicates on 8/24/2019 the Individual fell on the rocks. (Injury). GER was approved 9/4/2019. • General Events Report (GER) indicates on 8/26/2019 the Individual bent down to try and reach a piece of wood and fell. (Injury). GER was approved 9/4/2019. • General Events Report (GER) indicates on 8/29/2019 the Individual was trying to sit in the chair and lost balance. (Injury). GER was approved 9/4/2019. • General Events Report (GER) indicates on 8/30/2019 the Individual banged head on the wall. (Injury). GER was approved 9/4/2019. • General Events Report (GER) indicates on 8/30/2019 the Individual bit right forearm. (Injury). GER was approved 9/4/2019. • General Events Report (GER) indicates on 9/13/2019 the Individual banged head on the passenger rear window. (Injury). GER was approved 9/19/2019. • General Events Report (GER) indicates on 10/7/2019 the Individual was being assisted with a sponge bath when staff noticed a bruise on back and eye. (Injury). GER was approved 10/16/2019. 		
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	<ul style="list-style-type: none"> • General Events Report (GER) indicates on 10/29/2019 the Individual was walking in front of staff and fell in the hallway. (Fall without Injury). GER was approved 11/3/2019. • General Events Report (GER) indicates on 10/29/2019 the Individual reached out for an object off the sidewalk, lost balance and fell face forward onto the concrete. (Injury). GER was approved 11/3/2019. • General Events Report (GER) indicates on 11/3/2019 the Individual hit forehead on corner of the counter. (Injury). GER was approved 11/7/2019. • General Events Report (GER) indicates on 11/4/2019 the Individual was anxious and aggressive. (PRN Psychotropic Use). GER was approved 11/7/2019. • General Events Report (GER) indicates on 11/13/2019 staff noticed he had an injury on his right knee. (Injury). GER was approved 11/19/2019. <p>Individual #4</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 5/28/2019 the Individual ran away to mother's house. (AWOL/Missing Person). GER was approved 6/8/2019. • General Events Report (GER) indicates on 8/28/2019 the Individual said, "I am leaving" and continued outside walking through the back. (AWOL/Missing Person). GER was approved 9/4/2019. • General Events Report (GER) indicates on 10/16/2019 the Individual ran out the front 		
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door. (AWOL/Missing Person). GER was approved 10/21/2019.

Individual #6

- General Events Report (GER) indicates on 11/27/2018 the Individual began to feel nauseous and weak. Staff notified on call nurse, she advised individual to lay down and relax. Individual refused. (Hospital) GER was approved 12/4/2018.
- General Events Report (GER) indicates on 12/2/2018 the Individual dropped to the ground and showed seizure like activity for 5 seconds. (Fall Without Injury) GER was approved 12/6/2018.
- General Events Report (GER) indicates on 1/2/2018 the Individual became upset over tablet and was offered PRN twice but refused. Individual threatened physical harm to staff and self. Called 911. (Hospital) GER was approved 1/13/2019.
- General Events Report (GER) indicates on 1/8/2019 the Individual became upset and stormed out of restaurant. Individual calmed down and went home. Once at home, Individual took off again; Police were called. (Law Enforcement Involvement) GER was approved 1/13/2019.
- General Events Report (GER) indicates on 3/13/2019 the Individual started to raise her voice at staff and use profanity. (PRN Psychotropic Use) GER was approved 4/4/2019.
- General Events Report (GER) indicates on 3/14/2019 the Individual started yelling at staff and using profanity. Staff kept their distance

	<p>and after five minutes she returned to class. (AWOL/Missing Person) GER was approved 3/19/2019.</p> <ul style="list-style-type: none"> • General Events Report (GER) indicates on 3/14/2019 the Individual requested to take PRN before friends and relationships class. (PRN Psychotropic Use) GER was approved 4/4/2019. • General Events Report (GER) indicates on 3/15/2019 the Individual continued to escalate, yelling, using profanity, and threatening physical violence. Staff offered PRN and Individual agreed. (PRN Psychotropic Use) GER was approved 4/4/2019. • General Events Report (GER) indicates on 3/16/2019 the Individual was upset. Individual was redirected to the car to go for a drive and talk. Individual fell, started to cry and couldn't get up. (Hospital) GER was approved 4/4/2019. • General Events Report (GER) indicates on 3/24/2019 the Individual threatened to kill self. Called 911 this time. (Suicide) GER was approved 4/3/2019. • General Events Report (GER) indicates on 3/27/2019 the Individual was sitting on the floor seizing. (Hospital) GER was approved 4/4/2019. • General Events Report (GER) indicates on 4/1/2019 the Individual asked for a PRN. (PRN Psychotropic Use) GER was approved 4/4/2019. 		
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	<ul style="list-style-type: none"> • General Events Report (GER) indicates on 4/8/2019 the Individual walked from Walmart to Entrada Del Sol and picked up a piece of glass. (AWOL/Missing Person) GER was approved 4/15/2019. • General Events Report (GER) indicates on 4/9/2019 the Individual became physically and verbally aggressive. (Restraint Behavior) GER was approved 4/15/2019. • General Events Report (GER) indicates on 4/10/2019 the Individual was yelling at staff. (PRN Psychotropic Use) GER was approved 4/15/2019. • General Events Report (GER) indicates on 4/12/2019 staff performed a 2-hand sitting hold for 1 minute. (Restraint Behavior) GER was approved 5/2/2019. • General Events Report (GER) indicates on 4/24/2019 the Individual took off walking from parking lot. (AWOL/Missing Person) GER was approved 5/13/2019. • General Events Report (GER) indicates on 4/26/2019 Individual refused to get in the car and kept walking away from staff. (AWOL/Missing Person) GER was approved 5/14/2019. • General Events Report (GER) indicates on 5/24/2019 the Individual was seen at the urgent care. (Hospital) GER was approved 6/8/2019. • General Events Report (GER) indicates on 5/16/2019 staff performed a 2-arm standing restraint. (Restraint Behavior) GER was approved 5/22/2019. 		
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- General Events Report (GER) indicates on 5/28/2019 the Individual was dancing and fell back. (Fall without Injury) GER was approved 6/4/2019.
- General Events Report (GER) indicates on 6/4/2019 the Individual shoved the table and left. (AWOL/Missing Person) GER was approved 6/10/2019.
- General Events Report (GER) indicates on 6/20/2019 the Individual was restrained for 3 minutes. (Restraint Behavior) GER was approved 7/11/2019.
- General Events Report (GER) indicates on 6/26/2019 the Individual tripped on a rock and fell. (Injury) GER was approved 7/4/2019.
- General Events Report (GER) indicates on 6/27/2019 the Individual woke up yelling and refusing medications. BSC was contacted and suggested Individual goes to the hospital. (Hospital) GER was approved 7/11/2019.
- General Events Report (GER) indicates on 7/1/2019 the Individual was restrained for about a minute. (Restraint Behavior) GER was approved 7/4/2019.
- General Events Report (GER) indicates on 7/1/2019 the Individual was restrained for 2 minutes. (Restraint Behavior) GER was approved 7/4/2019.
- General Events Report (GER) indicates on 7/3/2019 staff did a two-arm standing restraint. (Restraint Behavior) GER was approved 7/11/2019.

	<ul style="list-style-type: none"> • General Events Report (GER) indicates on 7/5/2019 the Individual was scratching at a scar on abdomen. Staff restrained Individual's arms. (Restraint Behavior) GER was approved 7/22/2019. • General Events Report (GER) indicates on 7/5/2019 staff did a standing restraint for 1 minute. (Restraint Behavior) GER was approved 7/22/2019. • General Events Report (GER) indicates on 7/7/2019 the Individual had a seizure and was transported to the hospital. (Hospital) GER was approved 7/11/2019. • General Events Report (GER) indicates on 7/7/2019 the Individual eloped into the parking lot of the mall. (AWOL/Missing Person) GER was approved 7/11/2019. • General Events Report (GER) indicates on 7/11/2019 the Individual was assisted with PRN. (PRN Psychotropic Use) GER was approved 7/17/2019. • General Events Report (GER) indicates on 7/24/2019 staff put Individual's arms behind back. (Restraint behavior) GER was approved 7/27/2019. • General Events Report (GER) indicates on 7/24/2019 the Individual was restrained for about 1 minute. (Restraint Behavior) GER was approved 8/2/2019. • General Events Report (GER) indicates on 7/24/2019 the Individual went to the door and started kicking it. (PRN Psychotropic Use) GER was approved 7/27/2019. 		
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	<ul style="list-style-type: none"> • General Events Report (GER) indicates on 7/24/2019 the Individual got upset and scratched face. (Injury) GER was approved 7/27/2019. • General Events Report (GER) indicates on 7/26/2019 the Individual was restrained again for about 1 minute and let go. (Restraint Behavior) GER was approved 8/2/2019. • General Events Report (GER) indicates on 9/10/2019 staff restrained and put Individual in 2-arm sitting restraint. (Restraint Behavior) GER was approved 9/19/2019. • General Events Report (GER) indicates on 9/10/2019 the Individual was put in two-arm standing restraint for about 1 minute. (Restraint Behavior) GER was approved 9/19/2019. • General Events Report (GER) indicates on 9/10/2019 the Individual took off running as staff was locking the door to the home. (AWOL/Missing Person) GER was approved 9/19/2019. • General Events Report (GER) indicates on 9/14/2019 the Individual was eating lunch quickly and began to choke. (Injury). GER was approved 9/23/2019. • General Events Report (GER) indicates on 9/23/2019 the Individual tried to run but tripped and fell on back. (Injury). GER was approved 10/2/2019. • General Events Report (GER) indicates on 10/9/2019 the Individual was restrained for no more than 30 seconds. (Restraint Behavior). GER was approved 10/16/2019. 		
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| | <ul style="list-style-type: none">• General Events Report (GER) indicates on 11/5/2019 the Individual started banging left leg on the wall. (Injury). GER was approved 11/14/2019.• General Events Report (GER) indicates on 11/13/2019 the Individual asked for a PRN Clonazepam. (PRN Psychotropic Use). GER was approved 11/19/2019. | | |
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(Note: Findings for Individual #3 upheld by IRF 2/20/2020).

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Health and Welfare – 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.			
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up <i>(Upheld by IRF)</i>	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 3 Safeguards: 3.1.1 Decision Consultation Process (DCP): 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> <ol style="list-style-type: none"> 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; 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; health related recommendations or suggestions from oversight activities such 	<p>Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 1 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>Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):</p> <p>Annual Physical:</p> <ul style="list-style-type: none"> Not Linked / Attached in Therap (#5) <i>(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)</i> <p><i>(Note: Finding for Individual #5 upheld by IRF 2/20/2020).</i></p>	<p>Provider: 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>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>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>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements: All DD Waiver Provider</p>			
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<p>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"> 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 records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 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. 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. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored 			
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<p>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>20.5.3 Health Passport and Physician Consultation Form: All Primary and Secondary Provider Agencies must use the <i>Health Passport and Physician Consultation</i> 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 <i>Health Passport</i> also includes a standardized form to use at medical appointments called the <i>Physician Consultation</i> form. The <i>Physician Consultation</i> form contains a list of all current medications.</p> <p>Chapter 10: Living Care Arrangements (LCA) Living Supports-Supported Living: 10.3.9.6.1 Monitoring and Supervision</p> <p>4. Ensure and document the following:</p> <ul style="list-style-type: none"> a. The person has a Primary Care Practitioner. b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist. c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist. d. The person receives a hearing test as 			
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<p>recommended by a licensed audiologist.</p> <p>e. The person receives eye examinations as recommended by a licensed optometrist or ophthalmologist.</p> <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>10.3.10.1 Living Care Arrangements (LCA) Living Supports-IMLS: 10.3.10.2 General Requirements: 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>Chapter 13 Nursing Services: 13.2.3 General Requirements:</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>			
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Tag # 1A05 General Requirements / Agency Policy and Procedure Requirements <i>(Upheld by IRF)</i>	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 16: Qualified Provider Agencies Qualified DD Waiver Provider Agencies must deliver DD Waiver services. DD Waiver Provider Agencies must have a current Provider Agreement and continually meet required screening, licensure, accreditation, and training requirements as well as continually adhere to the DD Waiver Service Standards. All Provider Agencies must comply with contract management activities to include any type of quality assurance review and/or compliance review completed by DDSD, the Division of Health Improvement (DHI) or other state agencies.</p> <p>NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION: Provider Application</p> <ul style="list-style-type: none"> • Emergency and on-call procedures; • On-call nursing services that specifically state the nurse must be available to DSP during periods when a nurse is not present. The on-call nurse must be available to make an on-site visit when information provided by the DSP over the phone indicate, in the nurse's professional judgment, a need for a face to face assessment to determine appropriate action; • Incident Management Procedures that comply with the current NM Department of Health Improvement Incident Management Guide • Medication Assessment and Delivery Policy and Procedure; • Policy and procedures regarding delegation 	<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 interview, the Agency did not develop, implement and / or comply with written policies and procedures to protect the physical/mental health of individuals that complies with all DDSD requirements.</p> <p>When DSP were asked, what is the agency's on-call process, the following was reported:</p> <ul style="list-style-type: none"> • DSP #534 reported the on-call number as 575-636-██████. This number was called on 12/10/2019 at 5:20 pm. The call was not answered, and the voicemail box was full. No return call was received. Team Lead verified with the agency the above phone number was correct on 12/11/2019. (Individual #6) <p><i>(Note: Finding for on-call non response upheld by IRF 2/20/2020).</i></p>	<p>Provider: 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> </p> <p> </p> <p>Provider: 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> </p> <p> </p>	

<p>of specific nursing functions</p> <ul style="list-style-type: none"> • Policies and procedures regarding the safe transportation of individuals in the community and how you will comply with the New Mexico regulations governing the operation of motor vehicles <p>STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 39. POLICIES AND REGULATIONS</p> <p>Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD. Additionally, the PROVIDER agrees to abide by all the following, whenever relevant to the delivery of services specified under this Provider Agreement:</p> <ol style="list-style-type: none"> DD Waiver Service Standards and MF Waiver Service Standards. DEPARTMENT/DDSD Accreditation Mandate Policies. Policies and Procedures for Centralized Admission and Discharge Process for New Mexicans with Disabilities. Policies for Behavior Support Service Provisions. Rights of Individuals with Developmental Disabilities living in the Community, 7.26.3 NMAC. Service Plans for Individuals with Developmental Disability Community Programs, 7.26.5 NMAC. Requirement for Developmental Disability Community Programs, 7.26.6 NMAC. DEPARTMENT Client Complaint Procedures, 7.26.4 NMAC. Individual Transition Planning Process, 7.26.7 NMAC. 			
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<p>j. Dispute Resolution Process, 7.26.8 NMAC. k. DEPARTMENT/DDSD Training Policies and Procedures. l. Fair Labor Standards Act. m. New Mexico Nursing Practice Act and New Mexico Board of Nursing requirements governing certified medication aides and administration of medications, 16.12.5 NMAC. n. Incident Reporting and Investigation Requirements for Providers of Community Based Services, 7.14.3 NMAC, and DHI/DEPARTMENT Incident Management System Policies and Procedures. o. DHI/DEPARTMENT Statewide Mortality Review Policy and Procedures. p. Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. q. Quality Management System and Review Requirements for Providers of Community Based Services, 7.1.13 NMAC. r. All Medicaid Regulations of the Medical Assistance Division of the HS D. s. Health Insurance Portability and Accountability Act (HIPAA). t. DEPARTMENT Sanctions Policy. u. All other regulations, standards, policies and procedures, guidelines and interpretive memoranda of the DDSD and the DHI of the DEPARTMENT.</p> <p>Chapter 18 Incident Management: 18.1 Training on Abuse, Neglect, and Exploitation (ANE) Recognition and Reporting: All employees, contractors, and volunteers shall be trained on the in-person ANE training curriculum approved by DOH. Employees or volunteers can work with a DD Waiver participant prior to receiving the training only if directly supervised, at all times, by a trained staff. Provider Agencies are responsible for ensuring the training requirements outlined below are met.</p>			
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<p>1. DDS ANE On-line Refresher trainings shall be renewed annually, within one year of successful completion of the DDS ANE classroom training.</p> <p>2. Training shall be conducted in a language that is understood by the employee, subcontractor, or volunteer.</p> <p>3. Training must be conducted by a DOH certified trainer and in accordance with the Train the Trainer curriculum provided by the DOH.</p> <p>4. Documentation of an employee, subcontractor or volunteer's training must be maintained for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work.</p> <p>NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner.</p> <p>B. Training curriculum: Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The</p>			
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<p>training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer.</p> <p>D. Training documentation: All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule.</p> <p>NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:</p> <p>F. Quality assurance/quality improvement program for community-based service providers: The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include</p>			
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<p>written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program:</p> <ul style="list-style-type: none"> (1) community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; (2) community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and (3) community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues. 			
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Tag # 1A09.0 Medication Delivery Routine Medication Administration	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR): A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for:</p> <ol style="list-style-type: none"> 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: <ol style="list-style-type: none"> a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or 	<p>Medication Administration Records (MAR) were reviewed for the months of November and December 2019.</p> <p>Based on record review, 2 of 7 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</p> <p>Individual #4 November 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Famotidine 20 mg (2 times daily) <p>Individual #6 November 2019 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Fluoxetine HCL 20 MG (1 time daily) 	<p>Provider: 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> </p> <p> </p> <p>Provider: 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> </p> <p> </p>	<p> </p> <p> </p>

<p>treatments; over the counter (OTC) or “comfort” medications or treatments and all self-selected herbal or vitamin therapy;</p> <ul style="list-style-type: none"> c. Documentation of all time limited or discontinued medications or treatments; 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; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: <ul style="list-style-type: none"> 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; 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 iii. documentation of the effectiveness of the PRN medication or treatment. <p>Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery: Living Supports Provider Agencies must support and comply with:</p> <ul style="list-style-type: none"> 1. the processes identified in the DDSD AWMD training; 			
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<p>2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services;</p> <p>3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and</p> <p>4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. <p>Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p>			
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<p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none">➤ symptoms that indicate the use of the medication,➤ exact dosage to be used, and➤ the exact amount to be used in a 24-hour period.			
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Tag # 1A09.1 Medication Delivery PRN Medication Administration <i>(Upheld by IRF)</i>	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 20: Provider Documentation and Client Records 20.6 Medication Administration Record (MAR): A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for:</p> <ol style="list-style-type: none"> 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: <ol style="list-style-type: none"> a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or 	<p>Medication Administration Records (MAR) were reviewed for the months of November and December, 2019.</p> <p>Based on record review, 1 of 7 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:</p> <p>Individual #6 December 2019</p> <p>No evidence of documented Signs/Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> • Ibuprofen 200 mg – PRN –12/1 (given 1 time) • Tramadol HCL 50 mg – PRN –12/1, 2, 3, 4, 5 (given 2 times) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Tramadol HCL 50 mg – PRN –12/2 (given 1 time) • Ibuprofen 200 mg – PRN –12/1, 4 (given 1 time) <p>No Time of Administration was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Ibuprofen 200 mg – PRN –12/1(given 1 time) <p><i>(Note: Finding for Individual #6 upheld by IRF 2/20/2020).</i></p>	<p>Provider: 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>Provider: 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>treatments; over the counter (OTC) or “comfort” medications or treatments and all self-selected herbal or vitamin therapy;</p> <ul style="list-style-type: none"> c. Documentation of all time limited or discontinued medications or treatments; 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; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: <ul style="list-style-type: none"> 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; 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 iii. documentation of the effectiveness of the PRN medication or treatment. <p>Chapter 10 Living Care Arrangements 10.3.4 Medication Assessment and Delivery: Living Supports Provider Agencies must support and comply with:</p> <ul style="list-style-type: none"> 1. the processes identified in the DDSD AWMD training; 			
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<p>2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services;</p> <p>3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and</p> <p>4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).</p>			
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Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication <i>(Upheld by IRF)</i>	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 13 Nursing Services: 13.2.12 Medication Delivery: Nurses are required to:</p> <ol style="list-style-type: none"> 1. Be aware of the New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations. 2. Communicate with the Primary Care Practitioner and relevant specialists regarding medications and any concerns with medications or side effects. 3. Educate the person, guardian, family, and IDT regarding the use and implications of medications as needed. 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. 5. Monitor the MAR or treatment records at least monthly for accuracy, PRN use and errors. 6. Respond to calls requesting delivery of PRNs from AWMD trained DSP and non-related (surrogate or host) Family Living Provider Agencies. 7. Assure that orders for PRN medications or treatments have: <ol style="list-style-type: none"> a. clear instructions for use; b. observable signs/symptoms or circumstances in which the medication is to be used or withheld; and c. documentation of the response to and effectiveness of the PRN medication administered. 8. Monitor the person's response to the use of routine or PRN pain medication and contact the prescriber as needed regarding its effectiveness. 	<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 authorization as required by standard for 1 of 6 Individuals.</p> <p>Individual #6 December 2019</p> <p>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"> • Tramadol HCL 50 mg – PRN –12/3 (given 2 times) <p><i>(Note: Finding for Individual #6 upheld by IRF 2/20/2020).</i></p>	<p>Provider: 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> </p> <p> </p> <p>Provider: 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> </p> <p> </p>	<p> </p> <p> </p>

<p>9. Assure clear documentation when PRN medications are used, to include:</p> <ul style="list-style-type: none"> a. DSP contact with nurse prior to assisting with medication. <ul style="list-style-type: none"> 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 https://nmhealth.org/about/ddsd/pgsv/clinical/. b. Nursing instructions for use of the medication. c. Nursing follow-up on the results of the PRN use. d. When the nurse administers the PRN medication, the reasons why the medications were given and the person's response to the medication. 			
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Tag # 1A33.1 Board of Pharmacy – License <i>(Upheld by IRF)</i>	Standard Level Deficiency		
<p>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual Display of License and Inspection Reports The following are required to be publicly displayed:</p> <ul style="list-style-type: none"> • Current Custodial Drug Permit from the NM Board of Pharmacy • Current registration from the consultant pharmacist • Current NM Board of Pharmacy Inspection Report 	<p>Based on observation, the Agency did not provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 1 of 6 residences:</p> <p>Individual Residence:</p> <ul style="list-style-type: none"> • Current Custodial Drug Permit from the NM Board of Pharmacy with the current address of the residence (#3) <p><i>(Note: Finding for Individual #3 upheld by IRF 2/20/2020).</i></p>	<p>Provider: 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> </p> <p> </p> <p>Provider: 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> </p> <p> </p>	<p> </p> <p> </p>

Tag # LS25 Residential Health & Safety (Supported Living / Family Living / Intensive Medical Living) <i>(Upheld by IRF)</i>	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 10: Living Care Arrangements (LCA) 10.3.6 Requirements for Each Residence: Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence:</p> <ol style="list-style-type: none"> 1. has basic utilities, i.e., gas, power, water, and telephone; 2. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher; 3. has a general-purpose first aid kit; 4. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift; 5. has water temperature that does not exceed a safe temperature (110⁰ F); 6. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP; 7. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy; 8. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 9. supports environmental modifications and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the 	<p>Based on record review and / or observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 2 of 6 Living Care Arrangement residences.</p> <p>Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:</p> <p>Supported Living Requirements:</p> <ul style="list-style-type: none"> • Poison Control Phone Number (#1) • Emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 3) • Emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy (#1, 3) <p><i>(Note: Finding for Individual #3 upheld by IRF 2/20/2020).</i></p>	<p>Provider: 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> </p> <p> </p> <p>Provider: 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> </p> <p> </p>	<p> </p> <p> </p>

<p>individual in consultation with the IDT;</p> <ol style="list-style-type: none">10. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed;11. has the phone number for poison control within line of site of the telephone;12. has general household appliances, and kitchen and dining utensils;13. has proper food storage and cleaning supplies;14. has adequate food for three meals a day and individual preferences; and15. has at least two bathrooms for residences with more than two residents.			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Medicaid Billing/Reimbursement – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.			
Tag # LS27 Family Living Reimbursement (Upheld by IRF)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements: 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"> 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. 2. Comprehensive documentation of direct service delivery must include, at a minimum: <ol style="list-style-type: none"> a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and h. the nature of services. 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. 4. A Provider Agency that receives payment for treatment, services or goods must retain all 	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Family Living Services for 2 of 2 individuals.</p> <p>Individual #2 September 2019</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Family Living (T2033 HB) on 9/9/2019. Documentation did not contain the required elements on 9/9/2019. Documentation received accounted for 0 units. The required elements was not met: <ul style="list-style-type: none"> ➢ A description of what occurred during the encounter or service interval. <p>Individual #5 August 2019</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Family Living (T2033 HB) on 8/9/2019. Documentation did not contain the required elements on 8/9/2019. Documentation received accounted for 0 units. The required elements was not met: <ul style="list-style-type: none"> ➢ End time of each service encounter or other billable service interval; ➢ The signature or authenticated name of staff providing the service. • The Agency billed 1 unit of Family Living (T2033 HB) on 8/18/2019. Documentation did not contain the required elements on 8/18/2019. Documentation received accounted for 0 units. The required elements was not met: 	<p>Provider: 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>Provider: 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>medical and business records relating to any of the following for a period of at least six years from the payment date:</p> <ol style="list-style-type: none"> treatment or care of any eligible recipient; services or goods provided to any eligible recipient; amounts paid by MAD on behalf of any eligible recipient; and any records required by MAD for the administration of Medicaid. <p>21.9 Billable Units: 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>21.9.1 Requirements for Daily Units: For services billed in daily units, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> A day is considered 24 hours from midnight to midnight. 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. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. 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"> The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%). The receiving Provider Agency bills the remaining days up to 340 for the ISP year. 	<ul style="list-style-type: none"> ➤ End time of each service encounter or other billable service interval. <p>October 2019</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Family Living (T2033 HB) on 10/18/2019. Documentation did not contain the required elements on 10/18/2019. Documentation received accounted for 0 units. The required elements was not met: <ul style="list-style-type: none"> ➤ End time of each service encounter or other billable service interval. ➤ The signature or authenticated name of staff providing the service. <p><i>(Note: Finding for Individual #2 upheld by IRF 2/20/2020).</i></p>		
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<p>21.9.2 Requirements for Monthly Units: For services billed in monthly units, a Provider Agency must adhere to the following:</p> <ol style="list-style-type: none"> 1. A month is considered a period of 30 calendar days. 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. 3. Monthly units can be prorated by a half unit. 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>21.9.3 Requirements for 15-minute and hourly units: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> 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. 2. Services that last in their entirety less than eight minutes cannot be billed. 			
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Date: May 20, 2020

To: April Licon, Director/Owner
Provider: Quality Life Services, LLC
Address: 1051 N. Solano Drive
State/Zip: Las Cruces, New Mexico 88001

E-mail Address: April.licon@qlsnm.com

CC: Sally Chavez, Director
E-mail Address: Sally.chavez@qlsnm.com

Region: Southwest
Survey Date: December 6 -11, 2019

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2018:** Supported Living; Family Living; Customized In-Home Supports;
Customized Community Supports

Survey Type: Routine

Dear Ms. Licon and Ms. Chavez:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Monica Valdez, BS

Monica Valdez, BS
Healthcare Surveyor Advanced/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.20.2.DDW.75232383.3.RTN.09.20.141