Date:	May 8, 2020
To:	Anita Ahrens, Administrative Director
Provider:	Maxcare, Inc.
Address:	1114 Pennsylvania Street NE
State/Zip:	Albuquerque, NM 87110
E-mail Address:	anita@maxcarenm.com
CC:	Sara Buergi, Executive Director
Address:	1114 Pennsylvania Street NE
State/Zip:	Albuquerque, NM 87110
E-Mail Address:	sara@maxcarenm.com
Region:	Metro
Survey Date:	April 13 - 24, 2020
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Customized Community Supports~~,~~
Survey Type:	Routine
Team Leader:	Heather Driscoll, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Verna Newman-Sykes, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Anita Ahrens;

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:

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 # 1A09.1 Medication Delivery PRN Medication Administration
- Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medications
- Tag # 1A31 Client Rights / Human Rights

The following tags are identified as Standard Level:

- Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)
- Tag # 1A39 Assistive Technology and Adaptive Equipment
- Tag # LS26 Supported Living Reimbursement

Plan of Correction:

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

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

Corrective Action for Current Citation:

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

On-going Quality Assurance/Quality Improvement Processes:

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

Submission of your Plan of Correction:

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

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

1. **Quality Management Bureau, Attention: 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)

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 contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@state.nm.us 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,

Heather Driscoll

Heather Driscoll, AA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	April 13, 2020
Contact:	**Maxcare, Inc.** Anita Ahrens, Administrative Director **DOH/DHI/QMB** Heather Driscoll, AA, Team Lead/Healthcare Surveyor
Entrance Conference Date:	April 13, 2020
Present:	**Maxcare, Inc.** Anita Ahrens, Administrative Director Sara Buergi, Executive Director Cynthia Davis, Nurse Armida Medina, Program Director **DOH/DHI/QMB** Heather Driscoll, AA Team Lead/Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Verna Newman-Sykes, AA, Healthcare Surveyor
Exit Conference Date:	April 24, 2020
Present:	**Maxcare, Inc.** Anita Ahrens, Administrative Director Cynthia Davis, Nurse Armida Medina, Program Director **DOH/DHI/QMB** Heather Driscoll, AA Team Lead/Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Verna Newman-Sykes, AA, Healthcare Surveyor
Administrative Locations Visited:	0 *(Note: No administrative locations visited due to COVID- 19 Public Health Emergency)*
Total Sample Size:	6 0 - *Jackson* Class Members 6 - Non-*Jackson* Class Members 6 - Supported Living 6 - Customized Community Supports
Total Homes Visited	0 *(Note: No home visits conducted due to COVID- 19 Public Health Emergency)*
Persons Served Records Reviewed	6
Persons Served Interviewed	4
Persons Served Not Seen and/or Not Available	2 *(Note: 2 individuals chose not to participate in phone interviews)*
Direct Support Personnel Records Reviewed	43

Direct Support Personnel Interviewed	7
Service Coordinator Records Reviewed	1
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
- 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
- Quality Assurance / Improvement Plan

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

Attachment A

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

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

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued 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 completion 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 <u>Living Care Arrangements and Community Inclusion</u> are as follows:

<u>Service Domain: Service Plan: ISP Implementation -</u> *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)

<u>Service Domain: Qualified Providers -</u> *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.

Attachment D

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: **Maxcare, Inc. - Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Supported Living, Customized Community Supports
Survey Type: Routine
Survey Date: **April 13 – 24, 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 # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 22: Quality Improvement Strategy (QIS):** A QIS at the provider level is directly linked to the organization's service delivery approach or underlying provision of services. To achieve a higher level of performance and improve quality, an organization is required to have an efficient and effective QIS. The QIS is required to follow four key principles: 1. quality improvement work in systems and processes; 2. focus on participants; 3. focus on being part of the team; and 4. focus on use of the data. As part of a QIS, Provider Agencies are required to evaluate their performance based on the four key principles outlined above. Provider Agencies are required to identify areas of improvement, issues that impact quality of services, and areas of non-compliance with the DD Waiver Service Standards or any other program requirements. The findings should help inform the agency's QI plan.	Based on record review, the Agency did not maintain or implement a Quality Improvement System (QIS), as required by standards. Review of the Agency's Quality Improvement Plan provided during the survey did not address the following as required by Standards: **The Agency's QI Plan did not address one or more of the following KPI applies to the following provider types:** • % of appointments attended as recommended by medical professionals (physician, nurse practitioner or specialist). • % of people accessing Customized Community Supports in a non-disability specific setting.	**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?)*: → **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?)*: →	

22.2 QI Plan and Key Performance Indicators (KPI): Findings from a discovery process should result in a QI plan. The QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving goals, and identifying opportunities for improvement. The QI plan describes the processes that the Provider Agency uses in each phase of the QIS: discovery, remediation, and sustained improvement. It describes the frequency of data collection, the source and types of data gathered, as well as the methods used to analyze data and measure performance. The QI plan must describe how the data collected will be used to improve the delivery of services and must describe the methods used to evaluate whether implementation of improvements is working. The QI plan shall address, at minimum, three key performance indicators (KPI). The KPI are determined by DOH-DDSQI) on an annual basis or as determined necessary. ***22.3 Implementing a QI Committee:*** A QI committee must convene on at least a quarterly basis and more frequently if needed. The QI Committee convenes to review data; to identify any deficiencies, trends, patterns, or concerns; to remedy deficiencies; and to identify opportunities for QI. QI Committee meetings must be documented and include a review of at least the following: 1. Activities or processes related to discovery, i.e., monitoring and recording the findings; 2. The entities or individuals responsible for conducting the discovery/monitoring process; 3. The types of information used to measure performance; 4. The frequency with which performance is measured; and 5. The activities implemented to improve performance.			

22.4 Preparation of an Annual Report: The Provider Agency must complete an annual report based on the quality assurance (QA) activities and the QI Plan that the agency has implemented during the year. The annual report shall: 1. Be submitted to the DDSD PEU by February 15th of each calendar year. 2. Be kept on file at the agency, and made available to DOH, including DHI upon request. 3. Address the Provider Agency's QA or compliance with at least the following: a. compliance with DDSD Training Requirements; b. compliance with reporting requirements, including reporting of ANE; c. timely submission of documentation for budget development and approval; d. presence and completeness of required documentation; e. compliance with CCHS, EAR, and Licensing requirements as applicable; and f. a summary of all corrective plans implemented over the last 24 months, demonstrating closure with any deficiencies or findings as well as ongoing compliance and sustainability. Corrective plans include but are not limited to: i. IQR findings; ii. CPA Plans related to ANE reporting; iii. POCs related to QMB compliance surveys; and iv. PIPs related to Regional Office Contract Management. 4. Address the Provider Agency QI with at least the following:			

a. data analysis related to the DDSD required KPI; and b. the five elements required to be discussed by the QI committee each quarter. **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **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 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: **(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.			

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: 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: 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the month of March 2020. Based on record review, 3 of 6 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #2 March 2020 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Acetaminophen 500mg (PRN) • Chloraseptic Throat Spray (PRN) • Eucerin Cream/Lotion (PRN) • Mylanta (PRN) • Tums Antacid (PRN) Individual #3 March 2020 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Mucinex 600mg Tab ER 12 H – PRN – 3/28 (given 1 time) • Neilmed Sinus Rinse Packet – PRN – 3/25 (given 2 times) and 3/31 (given 1 time)	**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?)*: → **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?)*: →	

treatments; over the counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; 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: 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. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training;	Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • A & D Ointment/Desitin (PRN) • Milk of Magnesia (PRN) • Tylenol Sinus (PRN) Individual #6 March 2020 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • A & D Ointment/Desitin (PRN) • Acetaminophen 500 mg (PRN) • Chloraseptic Throat Spray (PRN) • Eucerin Cream/Lotion (PRN) • Ocean Mist Nasal Spray (PRN) • Tums Antacid Tablets (PRN)		

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).			

Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 13 Nursing Services: *13.2.12 Medication Delivery:*** Nurses are required to: 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: 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. 9. Assure clear documentation when PRN	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review the Agency did not maintain documentation of PRN authorization as required by standard for 1 of 6 Individuals. Individual #3 March 2020 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: • Mucinex 600mg – PRN – 3/28 (given 1 time) • Neilmed Sinus Rinse Packet – PRN – 3/25 (given 2 times) and 3/31 (given 1 time)	**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?)*: → **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?)*: →	

medications are used, to include: a. DSP contact with nurse prior to assisting with medication. 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.			

Tag # 1A31 Client Rights / Human Rights	Condition of Participation Level Deficiency		
NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review the Agency did not ensure the rights of Individuals was not restricted or limited for 1 of 6 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. <u>No documentation</u> was found regarding Human Rights Approval for the following: • Within arm's length near children. No evidence found of Human Rights Committee approval. (Individual #3)	**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?)*: → **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?)*: →	

Chapter 2: Human Rights: Civil rights apply to everyone, including all waiver participants, family members, guardians, natural supports, and Provider Agencies. Everyone has a responsibility to make sure those rights are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to best support the person. **Chapter 3 Safeguards: *3.3.1 HRC Procedural Requirements:*** 1. An invitation to participate in the HRC meeting of a rights restriction review will be given to the person (regardless of verbal or cognitive ability), his/her guardian, and/or a family member (if desired by the person), and the Behavior Support Consultant (BSC) at least 10 working days prior to the meeting (except for in emergency situations). If the person (and/or the guardian) does not wish to attend, his/her stated preferences may be brought to the meeting by someone whom the person chooses as his/her representative. 2. The Provider Agencies that are seeking to temporarily limit the person's right(s) (e.g., Living Supports, Community Inclusion, or BSC) are required to support the person's informed consent regarding the rights restriction, as well as their timely participation in the review. 3. The plan's author, designated staff (e.g., agency service coordinator) and/or the CM makes a written or oral presentation to the HRC. 4. The results of the HRC review are reported in writing to the person supported, the guardian, the BSC, the mental health or other specialized therapy provider, and the CM within three working days of the meeting. 5. HRC committees are required to meet at least on a quarterly basis.			

6. A quorum to conduct an HRC meeting is at least three voting members eligible to vote in each situation and at least one must be a community member at large. 7. HRC members who are directly involved in the services provided to the person must excuse themselves from voting in that situation. Each HRC is required to have a provision for emergency approval of rights restrictions based upon credible threats of harm against self or others that may arise between scheduled HRC meetings (e.g., locking up sharp knives after a serious attempt to injure self or others or a disclosure, with a credible plan, to seriously injure or kill someone). The confidential and HIPAA compliant emergency meeting may be via telephone, video or conference call, or secure email. Procedures may include an initial emergency phone meeting, and a subsequent follow-up emergency meeting in complex and/or ongoing situations. 8. The HRC with primary responsibility for implementation of the rights restriction will record all meeting minutes on an individual basis, i.e., each meeting discussion for an individual will be recorded separately, and minutes of all meetings will be retained at the agency for at least six years from the final date of continuance of the restriction. ***3.3.3 HRC and Behavioral Support:*** The HRC reviews temporary restrictions of rights that are related to medical issues or health and safety considerations such as decreased mobility (e.g., the use of bed rails due to risk of falling during the night while getting out of bed). However, other temporary restrictions may be implemented because of health and safety considerations arising from behavioral issues. Positive Behavioral Supports (PBS) are mandated and used when behavioral support is			

needed and desired by the person and/or the IDT. PBS emphasizes the acquisition and maintenance of positive skills (e.g. building healthy relationships) to increase the person's quality of life understanding that a natural reduction in other challenging behaviors will follow. At times, aversive interventions may be temporarily included as a part of a person's behavioral support (usually in the BCIP), and therefore, need to be reviewed prior to implementation as well as periodically while the restrictive intervention is in place. PBSPs not containing aversive interventions do not require HRC review or approval. Plans (e.g., ISPs, PBSPs, BCIPs PPMPs, and/or RMPs) that contain any aversive interventions are submitted to the HRC in advance of a meeting, except in emergency situations. **3.3.4 Interventions Requiring HRC Review and Approval:** HRCs must review prior to implementation, any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies, including but not limited to: 1. response cost; 2. restitution; 3. emergency physical restraint (EPR); 4. routine use of law enforcement as part of a BCIP; 5. routine use of emergency hospitalization procedures as part of a BCIP; 6. use of point systems; 7. use of intense, highly structured, and specialized treatment strategies, including level systems with response cost or failure to earn components; 8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons; 9. use of PRN psychotropic medications;			

10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand); 11. use of bed rails; 12. use of a device and/or monitoring system through PST may impact the person's privacy or other rights; or 13. use of any alarms to alert staff to a person's whereabouts. **3.4 Emergency Physical Restraint (EPR):** Every person shall be free from the use of restrictive physical crisis intervention measures that are unnecessary. Provider Agencies who support people who may occasionally need intervention such as Emergency Physical Restraint (EPR) are required to institute procedures to maximize safety. ***3.4.5 Human Rights Committee:*** The HRC reviews use of EPR. The BCIP may not be implemented without HRC review and approval whenever EPR or other restrictive measure(s) are included. Provider Agencies with an HRC are required to ensure that the HRCs: 1. participate in training regarding required constitution and oversight activities for HRCs; 2. review any BCIP, that include the use of EPR; 3. occur at least annually, occur in any quarter where EPR is used, and occur whenever any change to the BCIP is considered; 4. maintain HRC minutes approving or disallowing the use of EPR as written in a BCIP; and 5. maintain HRC minutes of meetings reviewing the implementation of the BCIP when EPR is used.			

Tag # 1A39 Assistive Technology and Adaptive Equipment	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: 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 individual in consultation with the IDT; **10.3.7 Scope of Living Supports (Supported Living, Family Living, and IMLS):** The scope of all Living Supports (Supported Living, Family Living and IMLS) includes, but is not limited to the following as identified by the IDT and ISP: 7. ensuring readily available access to and assistance with use of a person's adaptive equipment, augmentative communication, and assistive technology (AT) devices, including monitoring and support related to maintenance of such equipment and devices to ensure they are in working order; **Chapter 12: Professional and Clinical Services Therapy Services *12.4.1 Participatory Approach:*** The "Participatory Approach" is person-centered and asserts that no one is too severely disabled to benefit from assistive technology and other therapy supports that promote participation in life activities. The Participatory Approach rejects the premise that	Based on interview the Agency did not ensure the necessary support mechanisms and devices, including the rationale for the use of assistive technology or adaptive equipment is in place for 2 of 6 Individuals. **When DSP were asked, does the Individual require any type of assistive device or adaptive equipment and was it working, the following was reported:** • DSP #536 stated, "No, she doesn't have any." According to the Assistive Technology Inventory the individual wears glasses. (Individual #2) • DSP #538 stated, "Wheelchair and gait belt." According to the Assistive Technology Inventory the individual requires grab bars in the bathroom. (Individual #6)	**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?)*: → **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?)*: →	

an individual shall be “ready” or demonstrate certain skills before assistive technology can be provided to support function. All therapists are required to consider the Participatory Approach during assessment, treatment planning, and treatment implementation. **12.4.7.3 Assistive Technology (AT) Services, Personal Support Technology (PST) and Environmental Modifications:** Therapists support the person to access and utilize AT, PST and Environmental Modifications through the following requirements: 1. Therapists are required to be or become familiar with AT and PST related to that therapist’s practice area and used or needed by individuals on that therapist’s caseload. 2. Therapist are required to maintain a current AT Inventory in each Living Supports and CCS site where AT is used, for each person using AT related to that therapist’s scope of service. 3. Therapists are required to initiate or update the AT Inventory annually, by the 190th day following the person’s ISP effective date, so that it accurately identifies the assistive technology currently in use by the individual and related to that therapist’s scope of service. 4. Therapist are required to maintain professional documentation related to the delivery of services related to AT, PST and Environmental Modifications. (Refer to Chapter 14: Other Services for more information about these services.) 5. Therapists must respond to requests to perform in-home evaluations and make recommendations for environmental modifications, as appropriate. 6. Refer to the Publications section on the CSB page on the DOH web site (https://nmhealth.org/about/ddsd/pgsv/clinical/) for Therapy Technical Assistance documents.			

Chapter 11: Community Inclusion **11.6.2 General Service Requirements for CCS Individual, Small Group and Group:** CCS shall be provided based on the interests of the person and Desired Outcomes listed in the ISP. Requirements include: 1. Conducting community-based situational assessments, discovery activities or other person-centered assessments. The assessment will be used to guide the IDT's planning for overcoming barriers to employment and integrating clinical information, assistive technology and therapy supports as necessary for the person to be successful in employment. **11.7.2.2 Job Development:** Job development services through the DD Waiver can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16) and (17) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). 9. Facilitating/developing job accommodations and use of assistive technology such as communication devices.			

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 # LS26 Supported Living Reimbursement	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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: 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: 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	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 1 of 6 individuals. Individual #3 February 2020 • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 2/1/2020. Documentation received accounted for .5 units. As indicated by DDW Standards at least 12 hours in a 24-Hour period must be provided to bill a complete unit. Documentation accounted for 9 hours, which is less that the required amount. • The Agency billed 1 unit of Supported Living (T2016 HB U7) on 2/28/2020. Documentation received accounted for .5 units. As indicated by DDW Standards at least 12 hours in a 24-Hour period must be provided to bill a complete unit. Documentation accounted for 11.5 hours, which is less that the required amount.	**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?)*: → **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?)*: →	

medical and business records relating to any of the following for a period of at least six years from the payment date: a. treatment or care of any eligible recipient; b. services or goods provided to any eligible recipient; c. amounts paid by MAD on behalf of any eligible recipient; and d. any records required by MAD for the administration of Medicaid. **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. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: 1. A day is considered 24 hours from midnight to midnight. 2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period. 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. 4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows: a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%). b. The receiving Provider Agency bills the			

remaining days up to 340 for the ISP year. **21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days. 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. **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: 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.			

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date: July 13, 2020

To: Anita Ahrens, Administrative Director
Provider: Maxcare, Inc.
Address: 1114 Pennsylvania Street NE
State/Zip: Albuquerque, NM 87110

E-mail Address: anita@maxcarenm.com

CC: Sara Buergi, Executive Director
Address: 1114 Pennsylvania Street NE
State/Zip: Albuquerque, NM 87110

E-Mail Address: sara@maxcarenm.com

Region: Metro
Survey Date: April 13 - 24, 2020

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2018:*** Supported Living, Customized Community Supports,

Survey Type: Routine

Dear Ms. Ahrens:

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.20.4.DDW.D2513.5.RTN.09.20.195