

Date: September 21, 2010

To: Matt Poel, Executive Director  
Steven Nadolny, Administrative Director

Provider: Great Livin' LLC  
Address: 609 Broadway NE, Suite 217  
State/Zip: Albuquerque, New Mexico 87102

E-mail Address: [Matt@GreatLivin'.com](mailto:Matt@GreatLivin'.com)  
[Steven@GreatLivin'.com](mailto:Steven@GreatLivin'.com)

Region: Metro  
Survey Date: August 30 - September 7, 2010  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Living (Supported Living)  
Survey Type: Routine  
Team Leader: Stephanie R. Martinez de Berenger, MPA, GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Angie Helewicz, MA, Behavioral Liaison, Developmental Disabilities Service Division

Dear Mr. Poel:

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 contracts. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

**Quality Management Compliance Determination:**

The Division of Health Improvement is issuing your agency a determination of "Substantial Compliance with Conditions of Participation."

**Plan of Correction:**

The attached Report of Findings identifies deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. See attachment "A" for additional guidance in completing the Plan of Correction. The response is due to the parties below within 10 working days of the receipt of this letter:

- 1. Quality Management Bureau, Attention: Plan of Correction Coordinator  
5301 Central Ave. NE Suite 400 Albuquerque, NM 87108**
- 2. Developmental Disabilities Supports Division Regional Office for region of service surveyed**



*"Assuring safety and quality of care in New Mexico's health facilities and community-based programs."*  
**David Rodriguez, Division Director • Division of Health Improvement**  
Quality Management Bureau • 5301 Central Ave. NE Suite 400 • Albuquerque, New Mexico 87108  
(505) 222-8623 • FAX: (505) 222-8661 • <http://dhi.health.state.nm.us>

QMB Report of Findings – Great Livin', LLC - Metro Region – August 30 – September 7, 2010

Survey Report #: Q11.01.86879375.METRO.001.RTN.01

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

Failure to submit, complete or implement your Plan of Correction within the 45 day required time frames may result in the imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

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

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

QMB Deputy Bureau Chief  
5301 Central Ave NE Suite #400  
Albuquerque, NM 87108  
Attention: IRF request

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 working days. 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 at 505-222-8647 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,

*Stephanie R. Martinez de Berenger, M.P.A., GCDF*

Stephanie R. Martinez de Berenger, M.P.A., GCDF  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: August 30, 2010

Present: **Great Livin', LLC**  
Matt Poel, Executive Director

**DOH/DHI/QMB**  
Stephanie R. Martinez de Berenger, MPA, GCDF,  
Team Lead/Healthcare Surveyor

**DDSD – Metro Regional Office**  
Angie Helewicz, Behavioral Liaison

Exit Conference Date: September 2, 2010

Present: **Great Livin', LLC**  
Matt Poel, Executive Director  
Steven Nadolny, Administrative Director

**DOH/DHI/QMB**  
Stephanie R. Martinez de Berenger, MPA, GCDF,  
Team Lead/Healthcare Surveyor

**DDSD – Metro Regional Office**  
Angie Helewicz, MA, Behavioral Liaison

Homes Visited Number: 3

❖ Supported Homes Visited Number: 3

Administrative Locations Visited Number: 1

Total Sample Size Number: 3  
0 - Jackson Class Members  
3 - Non-Jackson Class Members  
3 - Supported Living

Persons Served Interviewed Number: 3

Direct Service Personnel Interviewed Number: 3

Records Reviewed (Persons Served) Number: 3

Administrative Files Reviewed

- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes
- Nursing personnel files
- Evacuation Drills
- Quality Improvement/Quality Assurance Plan

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

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

### **Introduction:**

After a QMB Compliance Review, your QMB Report of Findings will be sent to you via US 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 non compliance.

Agencies must submit their Plan of Correction within 10 business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 days will be referred to the Internal Review Committee [IRC] for sanctions).

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-222-8647 or email at [George.Perrault@state.nm.us](mailto:George.Perrault@state.nm.us). Requests for technical assistance must be requested through your DDS Regional Office.

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) days of receiving your report. The POC process cannot resolve disputes regarding findings. 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 to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan. (see page 3, DDW standards, effective; April 1, 2007, Chapter 1, Section I Continuous Quality Management System)

If a deficiency has already been corrected, 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 Plan of Correction you submit needs to address **each deficiency** in the two right hand columns with:

1. How the corrective action will be accomplished for all cited deficiencies in the report of findings;
2. How your Agency will identify all other individuals having the potential to be affected by the same deficient practice;
3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur and corrective action is sustained;
4. How your Agency plans to monitor corrective actions utilizing its continuous Quality Assurance/Quality Improvement Plan to assure solutions in the plan of correction are achieved and sustained, including (if appropriate):
  - Details about how and when Consumer, Personnel and Residential 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, as they are being used, and after they are completed;
  - Your processes for ensuring that all staff are trained in Core Competencies, Incident Reporting, and Individual-Specific service requirements, etc;
- How accuracy in Billing documentation is assured;
- How health, safety is assured;

- For Case Management Providers, how ISPs are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
  - Your process for gathering, analyzing and responding to Quality data, and
  - Details about Quality Targets in various areas, current status, Root Cause Analyses about why Targets were not met, and remedies implemented.
5. The individual's title responsible for the Plan of Correction and completion date.

**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 should 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). Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 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.

### **Plan of Correction Submission Requirements**

1. Your 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. If you have questions about the POC process, call the POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
  - a. Electronically at [George.Perrault@state.nm.us](mailto:George.Perrault@state.nm.us)
  - b. Faxed to 505-222-8661, or
  - c. Mailed to QMB, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not send supporting documentation to QMB until after your POC has been approved by QMB.
6. QMB will notify you when your POC has been "approve" or "denied."
  - a. 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 working 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 that your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 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.
8. 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 at QMB, 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.

### **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. You may submit your documents by postal mail, fax, or electronically on disc or 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; hard copies or scanned and electronically submitted copies are fine. 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. For billing deficiencies, you must submit:
  - a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
  - b. Copies of “void and adjust” forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

## QMB Scope and Severity Matrix

Each deficiency in your Report of Findings is scored on a Scope and Severity Scale. The culmination of each deficiency's Scope and Severity is used to determine degree of compliance to standards and regulations and level of QMB Compliance Determination.

		SCOPE			
		Isolated 01% - 15%	Pattern 16% - 79%	Widespread 80% - 100%	
SEVERITY	High Impact	Immediate Jeopardy to individual health and or safety	J.	K.	L.
		Actual harm	G.	H.	I.
	Medium Impact	No Actual Harm Potential for more than minimal harm	D.	E.	F. (3 or more)
			D. (2 or less)		F. (no conditions of participation)
	Low Impact	No Actual Harm Minimal potential for harm.	A.	B.	C.

### Scope and Severity Definitions:

- **Isolated:**  
A deficiency that is limited to 1% to 15% of the sample, usually impacting few individuals in the sample.
  
- **Pattern:**  
A deficiency that impacts a number or group of individuals from 16% to 79% of the sample is defined as a pattern finding. Pattern findings suggest the need for system wide corrective actions.
  
- **Widespread:**  
A deficiency that impacts most or all (80% to 100%) of the individuals in the sample is defined as widespread or pervasive. Widespread findings suggest the need for system wide corrective actions as well as the need to implement a Continuous Quality Improvement process to improve or build infrastructure. Widespread findings could be referred to the Internal Review Committee for review and possible actions or sanctions.

## QMB Determinations of Compliance

- “Substantial Compliance with Conditions of Participation”

The QMB determination of “Substantial Compliance with Conditions of Participation” indicates that a provider is in substantial compliance with all ‘Conditions of Participation’ and other standards and regulations. 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 Substantial Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation.

- “Non-Compliance with Conditions of Participation”

The QMB determination of “Non-Compliance with Conditions of Participation” indicates that a provider is out of compliance with one (1) or more ‘Conditions of Participation.’ This non-compliance, if not corrected, is likely to result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety.

Providers receiving a repeat determination of ‘Non-Compliance’ may be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- “Sub-Standard Compliance with Conditions of Participation”:

The QMB determination of “Sub-Standard Compliance with Conditions of Participation” indicates a provider is significantly out of compliance with Conditions of Participation and/or has:

- Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
- Any finding of actual harm or Immediate Jeopardy.

Providers receiving a repeat determination of ‘Substandard Compliance’ will be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

## **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 that surveyors have clarified issues and/or requested missing information before completing the review. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

### **Instructions:**

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.
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: <http://dhi.health.state.nm.us/qmb>
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.

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

- The request for an IRF and all supporting evidence must be received within 10 days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed 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 QMB compliance determination or the length of their DDSD provider contract.

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

QMB has 30 working days to complete the review and notify the provider of the decision. The request will be reviewed by the IRF committee. The Provider will be notified in writing of the ruling; no face to face meeting will be conducted.

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is 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.

**Agency:** Great Livin', LLC - Metro Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Living (Supported Living)  
**Monitoring Type:** Routine Survey  
**Date of Survey:** August 30 - September 7, 2010

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<b>Tag # 1A09 Medication Delivery (MAR) - Routine Medication</b>	<b>Scope and Severity Rating: D</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>E. Medication Delivery:</b> Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <p>(a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is</p>	<p>Medication Administration Records (MAR) were reviewed for the months of April, May &amp; June 2010.</p> <p>Based on record review, 1 of 3 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #1 April 2010 Medication Administration Records did not contain the strength for the following medications:</p> <ul style="list-style-type: none"> <li>• Athlete's Foot AF 1%</li> <li>• ICAPS Plus Tablet</li> </ul> <p>June 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Athlete's Foot AF 1% (2 times daily)</li> <li>• ICAPS Plus Tablet (2 times daily)</li> </ul> <p>Medication Administration Records did not contain the strength for the following medications:</p> <ul style="list-style-type: none"> <li>• Athlete's Foot AF 1%</li> <li>• ICAPS Plus Tablet</li> </ul>		

<p>prescribed;</p> <p>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p><b>NMAC 16.19.11.8 MINIMUM STANDARDS:</b>  <b>A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</b></p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, <b>including over-the-counter medications</b>. This documentation shall include:</p> <p>(i) Name of resident;</p> <p>(ii) Date given;</p>			
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- (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.

**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.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- 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.

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: D	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p><b>C. Orientation and Training Requirements:</b> Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <ol style="list-style-type: none"> <li>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</li> <li>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</li> </ol> <p><b>Department of Health (DOH)</b>  <b>Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.  B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 3 of 25 Direct Service Personnel.</p> <p>Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> <li>• Pre-Service (DSP #40)</li> <li>• First Aid (DSP #53 &amp; 58)</li> <li>• CPR (DSP #53 &amp; 58)</li> <li>• Participatory Communication &amp; Choice Making (DSP #53)</li> </ul>	

accordance with the specifications described in the individual service plan (ISP) of each individual served.

C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.

D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.

E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.

F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.

G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.

H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.

I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services.

Tag # 6L26 SL Reimbursement	Scope and Severity Rating: C	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>A. General:</b> All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p><b>B. Billable Units:</b> The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ol style="list-style-type: none"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ol> <p><b>MAD-MR: 03-59 Eff 1/1/2004</b></p> <p><b>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b></p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</b></p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 3 of 3 individuals.</p> <p>Individual #1 April 2010</p> <ul style="list-style-type: none"> <li>• The Agency billed 30 units of Supported Living Service from 4/01/2010 through 4/30/2010. Documentation did not contain start and end time on 4/2, 4, 5, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 27 &amp; 30, 2010 to justify billing.</li> </ul> <p>May 2010</p> <ul style="list-style-type: none"> <li>• The Agency billed 31 units of Supported Living Service from 5/01/2010 through 5/31/2010. Documentation did not contain start and end time on 5/ 1, 3, 4, 7, 8, 12, 13, 14, 18, 23, 24, 29 &amp; 31, 2010 to justify billing.</li> </ul> <p>June 2010</p> <ul style="list-style-type: none"> <li>• The Agency billed 29 units of Supported Living Service from 6/01/2010 through 6/30/2010. Documentation did not contain start and end time on 6/ 5, 8, 10, 14, 15, 17, 18, 19, 20, 26 &amp; 27, 2010 to justify billing.</li> </ul> <p>Individual #2 June 2010</p> <ul style="list-style-type: none"> <li>• The Agency billed 20 units of Supported Living Service from 6/01/2010 through 6/30/2010. Documentation did not contain start and end time on 6/ 8, 9, 13, 18, 23, 24 &amp; 28, 2010 to justify billing.</li> </ul> <p>Individual #3 April 2010</p> <ul style="list-style-type: none"> <li>• The Agency billed 30 units of Supported Living Service from 4/1/2010 through 4/30/2010. Documentation did not contain start and end</li> </ul>	

<p>A. <b>Reimbursement</b> for Supported Living Services</p> <p>(1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year.</p> <p>(2) <b>Billable Activities</b></p> <p>(a) Direct care provided to an individual in the residence any portion of the day.</p> <p>(b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community.</p> <p>(c) Any activities in which direct support staff provides in accordance with the Scope of Services.</p> <p>(3) Non-Billable Activities</p> <p>(a) The Supported Living Services provider shall not bill DD Waiver for Room and Board.</p> <p>(b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services.</p> <p>(c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.</p>	<p>time on 4/ 1, 2, 3, 6, 16, 17, 20, 22 &amp; 23, 2010 to justify billing.</p> <p>May 2010</p> <ul style="list-style-type: none"> <li>The Agency billed 28 units of Supported Living Service from 5/1/2010 through 5/31/2010. Documentation did not contain start and end time on 5/ 5, 7, 10, 11, 12, 13, 14, 15, 16, 21, 22 &amp; 24, 2010 to justify billing.</li> </ul> <p>June 2010</p> <ul style="list-style-type: none"> <li>The Agency billed 30 units of Supported Living Service from 6/01/2010 through 6/30/2010. Documentation did not contain start and end time on 6/ 4, 7, 11, 12, 15, 16, 23, 25 &amp; 30, 2010 to justify billing.</li> </ul>		
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Date: October 7, 2010  
To: Matt Poel, Executive Director  
Provider: Great Livin' LLC  
Address: 609 Broadway NE, Suite 217  
State/Zip: Albuquerque, New Mexico 87102

E-mail Address: [Matt@GreatLivin'.com](mailto:Matt@GreatLivin'.com)

Region: Metro  
Survey Date: August 30 - September 7, 2010  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Living (Supported Living)  
Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Mr. Poel,

Your request for a Reconsideration of Findings was received on October 6, 2010. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A09 (RTN Meds.)

Determination: The IRF committee is modifying the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies regarding the strength for "Athlete's Foot AF 1%," and "ICAP Plus Tablets," for Individual #1 will be removed. The remaining citations noted in this tag 1A09 were not disputed. The scope and severity rating will remain "D."

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

Thank you.

Respectfully,



Scott Good, MRC, CRC  
Deputy Bureau Chief/QMB  
Informal Reconsideration of Finding Committee Chair

CC:  
File  
DHI  
DDSD