

Date: May 16, 2011

To: Manish Gaur, Executive Director
 Provider: People Centered Day Habilitation Services
 Address: 509 Camino de Los Marquez #4
 State/Zip: Santa Fe, New Mexico 87505

E-mail Address: manishgaur@netzero.com

Region: Northeast
 Survey Date: March 28 – 31, 2011
 Program Surveyed: Developmental Disabilities Waiver
 Service Surveyed: Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
 Survey Type: Routine
 Team Leader: Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
 Team Members: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Anisa Fernandez, Community Inclusion Coordinator Developmental Disabilities Supports Division

Dear Mr. Gaur,

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 “Substandard 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 business 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**

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 business days. If your Plan of Correction is denied, you must resubmit a revised plan as



“Assuring safety and quality of care in New Mexico’s health facilities and community-based programs.”
Roger Gillespie, Acting 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 – People Centered Day Habilitation Services - Northeast Region – March 28 – 31, 2011

soon as possible for approval, as all remedies must still be completed within 45 business 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 business 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 business 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,

Nadine Romero, LBSW

Nadine Romero, LBSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

| | |
|--|--|
| Entrance Conference Date: | March 28, 2011 |
| Present: | <u>Person Centered Day Habilitation Services</u> Manish Gaur, Executive Director <u>DOH/DHI/QMB</u> Nadine Romero, LBSW, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor <u>DDSD - Northeast Regional Office</u> Anisa Fernandez, Community Inclusion Coordinator |
| Exit Conference Date: | March 31, 2011 |
| Present: | <u>Person Centered Day Habilitation Services</u> Manish Gaur, Executive Director Suzanne Marien, Supervisor Angelica Duran, Office Manager <u>DOH/DHI/QMB</u> Nadine Romero, LBSW, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor <u>DDSD - Northeast Regional Office</u> Anisa Fernandez, Community Inclusion Coordinator |
| Administrative Locations Visited | Number: 2 (1033 Paseo del Sur Suite H Taos, NM & 509 Camino de Los Marquez # 4 Santa Fe, NM) |
| Total Sample Size | Number: 8 1 - <i>Jackson</i> Class Members 7 - Non- <i>Jackson</i> Class Members 7 - Adult Habilitation 2 - Community Access 2 - Supported Employment |
| Persons Served Interviewed | Number: 8 |
| Records Reviewed (Persons Served) | Number: 8 |
| Direct Service Professionals Interviewed | Number: 7 |
| Direct Service Professionals Record Review | Number: 17 |
| Service Coordinator Record Review | Number: 1 |
| Administrative Files Reviewed | <ul style="list-style-type: none">• 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 |

- Evacuation Drills
- 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

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. 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
 - 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 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 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 DDS 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: People Centered Day Habilitation Services - Northeast Region
Program: Developmental Disabilities Waiver
Service: Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Routine Survey
Date of Survey: March 28 – 31, 2011

| Standard of Care | Deficiency | Agency Plan of Correction and Responsible Party | Date Due |
|--|---|---|----------|
| Tag # 1A06 Provider Agency Policy and Procedure Requirements | Scope and Severity Rating: C | | |
| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. II. PROVIDER AGENCY REQUIREMENTS: 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. Provider Agency Policy and Procedure Requirements: All Provider Agencies, in addition to requirements under each specific service standard shall at a minimum develop, implement and maintain, at the designated Provider Agency main office, documentation of policies and procedures for the following:</p> <ul style="list-style-type: none"> (1) Coordination of Provider Agency staff serving individuals within the program which delineates the specific roles of agency staff, including expectations for coordination with interdisciplinary team members who do not work for the provider agency; (2) Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated; and (3) Agency protocols for disaster planning and emergency preparedness. | <p>Based on record review, the Agency failed to implement and maintain, at the Agency main office, documentation of policies and procedures for the following:</p> <ul style="list-style-type: none"> (2) Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated; and | | |

| Tag # 1A08 Agency Case File | Scope and Severity Rating: B | |
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| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: 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>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <ol style="list-style-type: none"> (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the | <p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 6 of 8 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Did not contain Pharmacy Information (#6) • Annual ISP <ul style="list-style-type: none"> ◦ Incomplete (#3) • ISP Signature Page (#2) • ISP Teaching & Support Strategies <ul style="list-style-type: none"> ◦ Individual #2 - TASS not found for: ◦ Outcome Statement # 2 <ul style="list-style-type: none"> ➢ Will meet with Day Hab staff and together set up the picture schedule ➢ When presented with acting , say yes to participation ◦ Outcome Statement # 3 <ul style="list-style-type: none"> ➢ Will invite a friend to go swimming ➢ Will swim with her friend ◦ Individual #4 - TASS not found for: ◦ Outcome Statement # 3 <ul style="list-style-type: none"> ➢ Will research budgetary cost ➢ Will adapt DVD for the play ➢ Will assemble all necessary materials for production ◦ Individual #8 - TASS not found for: ◦ Outcome Statement # 2 <ul style="list-style-type: none"> ➢ Pulling up his pants ➢ Putting on his jacket ➢ Getting his own lunch | |

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| <p>developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p> | <ul style="list-style-type: none"> ➤ Return lunch box to cubby ◦ Outcome Statement # 3 <ul style="list-style-type: none"> ➤ Choose where he wants to go ➤ Show three pictures to choose an activity • Positive Behavioral Plan (#3 & 7) • Speech Therapy Plan (#4) • Occupational Therapy Plan (#2) • Physical Therapy Plan (#6) • Annual Physical (#2 & 3) • Dental Exam <ul style="list-style-type: none"> ◦ Individual #3 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • Vision Exam <ul style="list-style-type: none"> ◦ Individual #1 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #2 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #3 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found | | |
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| Tag # 1A08.1 Agency Case File - Progress Notes | Scope & Severity Rating: A | | |
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| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: 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>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <p>(3) Progress notes and other service delivery documentation;</p> | <p>Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 1 of 8 Individuals.</p> <p>Adult Habilitation Progress Notes/Daily Contact Logs</p> <ul style="list-style-type: none"> • Individual #3 - None found for 12/2010 – 2/2011 <p>Supported Employment Progress Notes/Daily Contact Logs</p> <ul style="list-style-type: none"> • Individual #3 - None found for 12/2010 – 2/2011 | | |

| Tag # 1A11.1 (CoP) Transportation Training | Scope and Severity Rating: E | | |
|---|---|--|--|
| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: 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>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date: March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:</p> <ol style="list-style-type: none"> 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency) | <p>Based on record review the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 5 of 17 Direct Service Professionals.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> • Transportation (DSP #40, 42, 45, 49 & 56) | | |

| Tag # 1A15 Healthcare Documentation - Nurse Contract/Employee | Scope and Severity Rating: F | | |
|---|---|--|--|
| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6 VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS K. Nursing Requirements and Roles (1) All Community Living Service Provider Agencies are required to have a registered nurse (RN) on staff. The agency nurse may be an employee or a sub-contractor.</p> <p>(3) A Community Living Support Provider Agency shall not use a licensed practical nurse (LPN) without a registered nurse (RN) supervisor.</p> | <p>Based on record review and interview, the Agency failed to provide an employed or contracted licensed registered nurse.</p> <p>Review of Agency records found no evidence of an employed or contracted nurse.</p> <p>When #57 was asked if the Agency had an employed or contracted licensed registered nurse, #57 stated, "Nurse just started a week ago." #57 was not able to produce nurse's contract or nursing license.</p> | | |

| Tag # 1A15.1 Nurse Availability | Scope and Severity Rating: E | | |
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| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>NEW MEXICO NURSING PRACTICE ACT CHAPTER 61, ARTICLE 3</p> <p>I. "licensed practical nursing" means the practice of a directed scope of nursing requiring basic knowledge of the biological, physical, social and behavioral sciences and nursing procedures, which practice is at the direction of a registered nurse, physician or dentist licensed to practice in this state. This practice includes but is not limited to:</p> <p>(1) contributing to the assessment of the health status of individuals, families and communities;</p> <p>(2) participating in the development and modification of the plan of care;</p> <p>(3) implementing appropriate aspects of the plan of care commensurate with education and verified competence;</p> <p>(4) collaborating with other health care professionals in the management of health care; and</p> <p>(5) participating in the evaluation of responses to interventions;</p> | <p>Based on interview, the Agency failed to ensure nursing services were available as needed for 4 of 7 individuals.</p> <p>When Direct Service Professionals (DSP) were asked about the availability of their agency nurse, the following was reported:</p> <ul style="list-style-type: none"> • DSP #40 stated, "I don't know where that is" (Individual #4) • DSP #42 stated, "A nurse is not needed, PCS has nurse in Santa Fe" (Individual #3) • DSP #45 stated, "No nurse is needed." (Individual #1) • DSP #48 stated, I think he has a nurse through R-Way, we have a nurse here but he doesn't take any meds." (Individual #5) | | |

| Tag # 1A15.2 & 5109 - Healthcare Documentation | Scope and Severity Rating: E | | |
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| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</p> <p>(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:</p> <ul style="list-style-type: none"> (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. <p>(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the</p> | <p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 3 of 8 individuals</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Health Assessment Tool (#4) • Medication Administration Assessment Tool (#3 & 4) <ul style="list-style-type: none"> • Nutritional Plan <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan • Crisis Plans <ul style="list-style-type: none"> • Seizures <ul style="list-style-type: none"> ◦ Individual #7 - As indicated by the IST section of ISP the individual is required to have a plan | | |

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| <p>agency nurse must be available to assist the caregiver upon request.</p> <p>(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first.</p> <p>(d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDS Medication Assessment and Delivery Policy).</p> <p>(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as <i>subjective</i> information including the individual complaints, signs and symptoms noted by staff, family members or other team members; <i>objective</i> information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); <i>assessment</i> of the clinical status, and <i>plan</i> of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p>(2) Health related plans</p> <p>(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare</p> | | | |
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| <p>professional.</p> <p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.</p> <p>(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.</p> <p>(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):</p> <p>(a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.</p> <p>(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.</p> <p>(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention</p> | | | |
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shall be specified in the plan.

(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.

(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.

(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.

(g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author.

(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.

(4) General Nursing Documentation

(a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.

(b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.

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CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS

B. IDT Coordination

(1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and

(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.

| Tag # 1A20 DSP Training Documents | Scope and Severity Rating: F | |
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| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>PERSONNEL: 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>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</p> <p>(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.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>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 16 of 17 Direct Service Professionals.</p> <p>Review of Direct Service Professionals training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> • Pre- Service (DSP #54 & 56) • Foundation for Health & Wellness :(DSP #54 & 56 • Person-Centered Planning (1-Day) (DSP #54 & 56) • First Aid (DSP #40, 42, 45, 53, 54 & 56) • CPR (DSP #40, 41, 42, 43, 44, 45, 47, 48, 50, 51, 53, 54 & 56) • Assisting With Medication Delivery (DSP #40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54 & 56) • Participatory Communication & Choice Making (DSP #49 & 56) • Rights & Advocacy (DSP #49) • Level 1 Health (DSP #42 & 49) • Positive Behavior Supports Strategies (DSP #49) • Teaching & Support Strategies (DSP #49 & 53) | |

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 # 1A25 (CoP) CCHS | Scope and Severity Rating: E | |
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| <p>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</p> <p>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</p> <p>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: A. homicide; B. trafficking, or trafficking in controlled substances; C. kidnapping, false imprisonment, aggravated assault or aggravated battery; D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; E. crimes involving adult abuse, neglect or financial exploitation; F. crimes involving child abuse or neglect; G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p> | <p>Based on record review, the Agency failed to maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 14 of 18 Agency Personnel.</p> <p>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</p> <ul style="list-style-type: none"> • #40 – Date of Hire 7/2/2010 • #42 – Date of Hire 12/1/2009 • #43 – Date of Hire 4/12/2010 • #44 – Date of Hire 7/30/2007 • #45 – Date of Hire 3/8/2010 • #46 – Date of Hire 4/16/2007 • #47 – Date of Hire 10/15/2008 • #49 – Date of Hire 10/19/2009 • #50 – Date of Hire 1/23/2009 • #51 – Date of Hire 7/12/2007 • #52 – Date of Hire 11/18/2008 • #54 – Date of Hire 7/9/2010 • #55 – Date of Hire 3/21/2011 • #56 – Date of Hire 8/24/2010 | |

| Tag # 1A26 (CoP) COR / EAR | Scope and Severity Rating: F | | |
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| <p>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. Documentation for other staff. With</p> | <p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 18 of 18 Agency Personnel.</p> <p>The following Agency personnel records contained no evidence of the Employee Abuse Registry being completed:</p> <ul style="list-style-type: none"> • #56 – Date of Hire 8/24/10 <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #40 – Date of Hire 7/2/2010 • #41 – Date of Hire 11/29/2007 • #42 – Date of Hire 12/1/2009 • #43 – Date of Hire 4/12/2010 • #44 – Date of Hire 7/30/2007 • #45 – Date of Hire 3/8/2010 • #46 – Date of Hire 4/16/2007 • #47 – Date of Hire 10/15/2008 • #48 – Date of Hire 4/23/2008 • #49 – Date of Hire 10/19/2009 • #50 – Date of Hire 1/23/2009 • #51 – Date of Hire 7/12/2007 • #52 – Date of Hire 11/18/2008 | | |

respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.

F. **Consequences of noncompliance.** The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.

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Chapter 1.IV. General Provider Requirements.

D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

- #53 – Date of Hire 12/2/2008
- #54 – Date of Hire 7/9/2010
- #55 – Date of Hire 3/21/2011
- #57 – Date of Hire 4/23/07

| Tag # 1A27 (CoP) Late & Failure to Report | Scope and Severity Rating: D | | |
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| <p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>A. Duty To Report:</p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</p> <p>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</p> <p>B. Notification: (1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.</p> | <p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 9 individuals.</p> <p>Individual #9</p> <ul style="list-style-type: none"> • Incident date 3/26/2010. Allegation was Neglect. Incident report was received 3/26/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." | | |

| Tag # 1A27.2 (CoP) Duty to Report - IR's Filed During On-Site and/or IR's Not Reported by Provider | Scope and Severity Rating: D | | |
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| <p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>A. Duty To Report:</p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</p> <p>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</p> <p>B. Notification:</p> <p>(1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website; http://dhi.health.state.nm.us/elibrary/ironline/ir.php</p> | <p>Based on record review and interview, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 8 Individuals.</p> <p>During the on-site visit the Team Lead interviewed #57 regarding their Human Rights Committee and if any of the individuals on the sample required any type of restraints. During the interview #57 stated, "#5 uses a dog harness while toileting. This device is used to restrain #5 to keep #5 from getting up from the toilet."</p> <p>When #57 was asked if there was a Human Rights Approval for the "dog harness." #57 reported No.</p> <p>As a result of this interview a State Incident Report of Neglect was filed on March 30, 2011 on behalf of Individual #5</p> | | |

or may be obtained from the department by calling the toll free number.

(2) Division Incident Report Form and Notification by Community Based Service Providers:

The community based service provider shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide. The community based service provider shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The community based service provider shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.

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| Tag # 1A28.1 (CoP) Incident Mgt. System - Personnel Training | Scope & Severity Rating: F | | |
| <p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p> <p>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p> | <p>Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 18 of 18 Agency Personnel.</p> <ul style="list-style-type: none"> Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, & 57) | | |

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| Tag # 1A28.2 (CoP) Incident Mgt. System - Parent/Guardian Training | Scope & Severity Rating: E | | |
| <p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>E. Consumer and Guardian Orientation Packet: Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.</p> | <p>Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 2 of 8 individuals.</p> <ul style="list-style-type: none"> • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#2 & 7) | | |

| Tag # 1A29 Complaints / Grievances - Acknowledgement | Scope and Severity Rating: A | | |
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| <p>NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC].</p> <p>NMAC 7.26.3.13 Client Complaint Procedure Available. A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p>NMAC 7.26.4.13 Complaint Process: A. (2). The service provider's complaint or grievance procedure shall provide, at a minimum, that: (a) the client is notified of the service provider's complaint or grievance procedure</p> | <p>Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 8 individuals.</p> <ul style="list-style-type: none"> Grievance/Complaint Procedure Acknowledgement (#2) | | |

| Tag # 1A31 (CoP) Client Rights/Human Rights | Scope and Severity Rating: D | | |
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| <p>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:</p> <p>A. A service provider shall not restrict or limit a client's rights except:</p> <p>(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</p> <p>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</p> <p>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</p> <p>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.</p> <p>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]</p> <p>Long Term Services Division Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003 IV. POLICY STATEMENT - Human Rights Committees are required for residential service provider agencies. The purpose of these</p> | <p>Based on record review and interview, the Agency failed to ensure the rights of Individuals was not restricted or limited for 1 of 9 Individuals.</p> <p>A review of Agency Individual files found no documentation of Positive Behavior Plans and/or Positive Behavior Crisis Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (#5)</p> <p>A review of Agency Individual files indicated 1 of 8 Individuals required Human Rights Committee Approval for restrictions.</p> <p>No documentation was found regarding Human Rights Approval for the following:</p> <ul style="list-style-type: none"> • Physical Restraint (Dog Harness used for toileting purposes) (Individual #5) | | |

committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:

- Aversive Intervention Prohibitions
- Psychotropic Medications Use
- Behavioral Support Service Provision.

A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS

Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval.

2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan.

Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006

B. 1. e. If the PRN medication is to be used in

response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).

| Tag # 1A32 (CoP) ISP Implementation | Scope and Severity Rating: E | |
|--|--|--|
| <p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p> | <p>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 2 of 8 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #6</p> <ul style="list-style-type: none"> • None found for 12/2010 – 2/2011 <p>Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #7</p> <ul style="list-style-type: none"> • None found for 12/2010 – 2/2011 | |

| Tag # 1A33.1 Board of Pharmacy - Lic | Scope and Severity Rating: C | | |
|---|---|--|--|
| <p>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</p> <p>6. Display of License and Inspection Reports</p> <p>A. The following are required to be publicly displayed:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current Custodial Drug Permit from the NM Board of Pharmacy <input type="checkbox"/> Current registration from the consultant pharmacist <input type="checkbox"/> Current NM Board of Pharmacy Inspection Report | <p>Based on observation, the Agency failed to provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 2 of 2 Facilities:</p> <p>Facility (Person Centered Day Habilitation Services 509 Camino de Los Marquez #4 Santa Fe, NM & 1033 Paseo del Sur Suite H Taos, NM)</p> <ul style="list-style-type: none"> • Current Custodial Drug Permit from the NM Board of Pharmacy (Location: Santa Fe & Taos) • Current Registration of Consulting Pharmacist (Location: Santa Fe & Taos) • Current NM Board of Pharmacy Inspection report (Location: Santa Fe & Taos) | | |

| Tag # 1A37 Individual Specific Training | Scope and Severity Rating: E | |
|--|--|--|
| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>PERSONNEL: 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>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (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.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 -</p> <p>II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</p> | <p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 10 of 18 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <ul style="list-style-type: none"> • Individual Specific Training (#40, 42, 43, 45, 48, 49, 50, 52, 53 & 56) | |

| Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports) | Scope and Severity Rating: A | | |
|--|---|--|--|
| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</p> <p>E. Provider Agency Reporting Requirements: All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation:</p> <ol style="list-style-type: none"> (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: <ol style="list-style-type: none"> (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD. | <p>Based on record review, the Agency failed to complete quarterly reports as required for 1 of 8 individuals receiving Community Inclusion services.</p> <p>Adult Habilitation Quarterly Reports</p> <ul style="list-style-type: none"> • Individual #8 - None found for 4/2010 – 12//2010 | | |

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

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

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

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

Policy Title: Vocational Assessment Profile

Policy Eff July 16, 2008

I. PURPOSE

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

II. POLICY STATEMENT

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

| Tag # 5I36 CA Reimbursement | Scope and Severity Rating: B | | |
|---|---|--|--|
| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>A. General: 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. Billable Units: 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"> (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</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>CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS</p> | <p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 1 of 2 individuals.</p> <p>Individual #7 December 2010</p> <ul style="list-style-type: none"> • The Agency billed 16 units of Community Access from 12/28/2010 through 12/31/2010. No documentation found to justify billing. <p>February 2011</p> <ul style="list-style-type: none"> • The Agency billed 62 units of Community Access from 2/1/2011 through 2/3/2011. Documentation received accounted for 25 units. • The Agency billed 79 units of Community Access from 2/09/2011 through 2/15/2011. Documentation received accounted for 75 units. | | |

G. Reimbursement

(1) **Billable Unit:** A billable unit is defined as one-quarter hour of service.

(2) **Billable Activities:** The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions:

- (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan;
- (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and
- (c) Non face-to-face hours do not exceed 10% of the monthly billable hours.

(3) **Non-Billable Activities:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:

- (a) Time and expense for training service personnel;
- (b) Supervision of agency staff;
- (c) Service documentation and billing activities; or
- (d) Time the individual spends in segregated facility-based settings activities.

| Tag # 5144 AH Reimbursement | Scope and Severity Rating: C | |
|--|--|--|
| <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>A. General: 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. Billable Units: 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"> (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</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>CHAPTER 5 XVI. REIMBURSEMENT</p> <p>A. Billable Unit. A billable unit for Adult Habilitation</p> | <p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 7 of 7 individuals.</p> <p>Individual #1 December 2010</p> <ul style="list-style-type: none"> • The Agency billed 47 units of Adult Habilitation from 12/28/2010 through 12/31/2010. No documentation found to justify billing. <p>February 2011</p> <ul style="list-style-type: none"> • The Agency billed 94 units of Adult Habilitation from 2/23/11 through 3/1/11 Documentation received accounted for 69 units. <p>Individual #2 December 2010</p> <ul style="list-style-type: none"> • The Agency billed 25 units of Adult Habilitation from 12/01/10 through 12/07/2010. Documentation received accounted for 21 units. <p>Individual #3 December 2010</p> <ul style="list-style-type: none"> • The Agency billed 35 units of Adult Habilitation from 12/28/2010 through 12/31/2010. No documentation found to justify billing. <p>February 2011</p> <ul style="list-style-type: none"> • The Agency billed 17 units of Adult Habilitation from 2/02/2011. No documentation found to justify billing. • The Agency billed 21 units of Adult Habilitation from 2/08/11. Documentation received accounted for 4 units. • The Agency billed 71 units of Adult Habilitation from 2/16/2011 through 2/22/2011. Documentation received accounted for 60 units. | |

Services is in 15-minute increments hour. The rate is based on the individual's level of care.

B. Billable Activities

(1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours.

(2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours

- The Agency billed 98 units of Adult Habilitation from 2/23/2011 through 2/28/2011. Documentation received accounted for 77 units.

Individual #4
December 2010

- The Agency billed 44 units of Adult Habilitation from 12/08/2010 through 12/14/2010. Documentation received accounted for 41 units.

February 2011

- The Agency billed 118 units of Adult Habilitation from 2/16/2011 through 2/22/2011. Documentation received accounted for 114 units.
- The Agency billed 218 units of Adult Habilitation from 2/23/2011 through 2/28/2011. Documentation received accounted for 93 units.

Individual #5
December 2010

- The Agency billed 140 units of Adult Habilitation from 12/01/2010 through 12/07/2010. No documentation found to justify billing.
- The Agency billed 140 units of Adult Habilitation from 12/08/2010 through 12/14/2010. Documentation received accounted for 112 units.

February 2011

- The Agency billed 140 units of Adult Habilitation from 2/9/2011 through 2/15/2011. Documentation received accounted for 138 units.
- The Agency billed 140 units of Adult Habilitation from 2/16/2011 through 2/22/2011. Documentation received accounted for 128 units.

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| | <p>Individual #6 January 2011</p> <ul style="list-style-type: none"> • The Agency billed 102 units of Adult Habilitation from 1/26/2011 through 1/31/2011. Documentation received accounted for 42.25 units. <p>February 2011</p> <ul style="list-style-type: none"> • The Agency billed 65 units of Adult Habilitation from 2/02/2011 through 2/08/2011. Documentation received accounted for 45 units. • The Agency billed 115 units of Adult Habilitation from 2/09/2011 through 2/15/2011. Documentation received accounted for 26 units. • The Agency billed 126 units of Adult Habilitation from 2/16/2011 through 2/22/2011. Documentation received accounted for 77 units. • The Agency billed 123 units of Adult Habilitation from 2/23/2011 through 2/28/2011. Documentation received accounted for 93 units. <p>Individual #8 December 2010</p> <ul style="list-style-type: none"> • The Agency billed 125 units of Adult Habilitation from 12/01/2010 through 12/07/2010. Documentation received accounted for 121 units. • The Agency billed 135 units of Adult Habilitation from 12/08/2010 through 12/14/2010. Documentation received accounted for 125 units. <p>January 2011</p> <ul style="list-style-type: none"> • The Agency billed 24 units of Adult Habilitation from 1/01/2011 through 1/04/2011. No documentation found to justify billing. <p>February 2011</p> | | |
|--|---|--|--|

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| | <ul style="list-style-type: none"> • The Agency billed 129 units of Adult Habilitation from 2/23/2011 through 2/28/2011. Documentation received accounted for 104 units. | | |
|--|---|--|--|

Date: June 22, 2011

To: Manish Gaur, Executive Director
 Provider: People Centered Day Habilitation Services
 Address: 509 Camino de Los Marquez #4
 State/Zip: Santa Fe, New Mexico 87505

E-mail Address: manishgaur@netzero.com

Region: Northeast
 Survey Date: March 28 – 31, 2011
 Program Surveyed: Developmental Disabilities Waiver
 Service Surveyed: Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
 Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Mr. Gaur,

Your request for a Reconsideration of Findings was received on June 3, 2011. 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 Tags # 1A08 - 1A08.1 - 1A25 - 1A28.2 - 1A15.2/5I09 and 1A32

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the Plan of Correction as previously indicated. Based on the IRF form submitted by you there was no rationale for a dispute of the findings, "file," "in book," or "in file," is not a rationale for the dispute of a finding. Also in requests for IRF there was evidence in the records which detail the request for documentation being made and not received by the time allotted by the Survey Team Lead. The scope and severity ratings will remain the same.

Regarding Tag # 1A15

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the DSP interview conducted, the competency level of the staff was the issue found deficient, not whether the training of the staff occurred. The scope and severity rating for this tag will remain "E."

Regarding Tag # 1A11.1 and 1A20

Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the documentation supplied and conversations between the Team Lead and yourself after the survey the findings for #56 will be removed. There is a clarification which needs to be stated, however, when asked during the survey the status of #56 the survey team was informed by your staff that #56 was indeed a staff member working for your agency and not an Individual in services. The remaining citations noted in tag were not disputed. The scope and severity rating for this tag will remain "F," and "E," respectively.

Regarding Tag # 1A06

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied the policy/procedure does not specifically address the response to individual emergency medical situations, including staff training for emergency response and on-call systems as required. The scope and severity rating will remain "C."

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
Deputy Bureau Chief/QMB

Informal Reconsideration of Finding Committee Chair