Date:	December 14, 2009
To:	Nancy Parsons, President
Provider:	Blue Sky Case Management, Inc.
Address:	2632 Pennsylvania NE Suite D
State/Zip:	Albuquerque, New Mexico 87110
E-mail Address:	bluescasemanag@questoffice.net
Region:	Metro
Survey Date:	October 19 – 22, 2009
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Case Management
Survey Type:	Routine
Team Leader:	Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Crystal Lopez – Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau;

Dear Mrs. Parsons,

The Division of Health Improvement/Quality Management Bureau has completed a quality review 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.

Quality Management Approval Rating:
The Division of Health Improvement is pleased to issue your agency a "MERIT" rating for compliance with DDSD Standards and regulations.

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

1. Quality Management Bureau, Attention: Plan of Correction Coordinator
   5301 Central Ave. NE Suite 400 Albuquerque, NM 87108

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

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 working days. If your plan of correction is denied, you must resubmit a revised plan ASAP for approval. All remedies must still be completed within 45 working days of the original submission.

Failure to submit, complete or implement your POC within the required time frames will 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 determination of noncompliance (finding) you have 10 working days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

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

A request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 working days. Providers may not appeal the nature or interpretation of the standard or regulation, the team composition, sampling methodology or the Scope and Severity of the finding.

If the IRF approves the change or removal of a finding, you will be advised of any changes.

This IRF process is separate and apart from the Informal Dispute Resolution (IDR) and Fair Hearing Process for Sanctions from DOH.

Please call the Team Leader at 505-670-6290 if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

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

Survey Process Employed:

Entrance Conference Date:	October 19, 2009	
Present:	**Blue Sky Case Management, Inc** Nancy Parsons, President **DOH/DHI/QMB** Nadine Romero, LBSW, Team Lead/Healthcare Surveyor Crystal Lopez – Beck, BA, Healthcare Surveyor	
Exit Conference Date:	October 22, 2009	
Present:	**Blue Sky Case Management** Nancy Parsons, President Randy Parsons, Vice President **DOH/DHI/QMB** Nadine Romero, LBSW, Team Lead/Healthcare Surveyor Crystal Lopez- Beck, BA, Healthcare Surveyor	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	22 5 - Jackson Class Members 17 - Non-Jackson Class Members
Case Managers Interviewed	Number:	4
Case Manager Personnel Record Review:	Number:	4
Records Reviewed (Persons Served)	Number:	22

Administrative Files Reviewed

- Billing Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Quality Improvement/Quality Assurance Plan

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

Attachment A

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8647.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency ("Responsible Party"), and by WHEN ("Date Due").
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency's Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-222-8661), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been "Approved" or "Denied".
- Whether your POC is "Approved" or "Denied", you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is "Denied" it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- The following Deficiencies must be corrected within the deadlines below (after receipt of your Survey Report):

    - CCHS and EAR: 10 working days
    - Medication errors: 10 working days
    - IMS system/training: 20 working days
    - ISP related documentation: 30 working days
    - DDSD Training 45 working days

- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8647 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Attachment B

QMB Scope and Severity Matrix of survey results

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 Certification.

			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:

Key to Scope scale:
Isolated:
A deficiency that is limited to 1% to 15% of the sample, usually impacting no more than one or two 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 must be referred to the Internal Review Committee for review and possible actions or sanctions.

Key to Severity scale:
Low Impact Severity: (Blue)
Low level findings have no or minimal potential for harm to an individual. Providers that have no findings above a "C" level may receive a "Quality" Certification approval rating from QMB.

Medium Impact Severity: (Tan)
Medium level findings have a potential for harm to an individual. Providers that have no findings above a "F" level and/or no more than two F level findings and no F level Conditions of Participation may receive a "Merit" Certification approval rating from QMB.

High Impact Severity: (Green or Yellow)
High level findings are when harm to an individual has occurred. Providers that have no findings above "I" level may only receive a "Standard" Approval rating from QMB and will be referred to the IRC.

High Impact Severity: (Yellow)
"J, K, and L" Level findings:
This is a finding of Immediate Jeopardy. If a provider is found to have "I" level findings or higher, with an outcome of Immediate Jeopardy, including repeat findings or Conditions of Participation they will be referred to the Internal Review Committee.

The QMB Approval Rating

The QMB approval rating is the provider incentive to encourage quality service and correlates the review outcome with the QMB review frequency and its recommendation to DDSD to determine the length of the provider agreement. The "Approval rating" is based on the Scope and Severity of the review findings. There are five levels of "Approval" that a provider may receive. They are:

"Quality" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Quality" Rating. To qualify for a QMB "Quality" rating of approval" and a three (3) year QMB review cycle and provider agreement recommendation, the provider must not have any findings that are a condition of participation and no findings of "F" level or higher on the Scope and Severity Matrix with no more that three (3) D or E level findings.

"Merit" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Merit" Rating. To qualify for a QMB "Merit" rating of approval" and a two (2) year QMB review cycle and provider agreement recommendation, the provider must not have more than three (3) findings that are a condition of participation and no more than three (3) "F" level findings with no findings of a "G" level or higher on the Scope and Severity Matrix and no more that six (6) D or E level findings.

"Standard" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Standard" Rating. To qualify for a QMB "Standard" rating of approval" and a one (1) year QMB review cycle and provider agreement recommendation, the provider must not have more than six (6) findings that are a condition of participation and no more than six (6) "F" level findings with no findings of a "G" level or higher on the Scope and Severity Matrix and no more that six (6) D or E level findings.

"Sub-Standard" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider has "Sub-standard" performance. To qualify for a QMB "Sub-Standard" rating of approval" and a three to six month QMB review cycle, with a referral to the Internal Review Committee and provider agreement recommendation, the provider may have any of the following findings:

- seven (7) or more findings that are a condition of participation
- seven (7) or more "F" level findings
- any findings of a "G" level or higher
- nine (9) or more D or E level findings

A referral to the IRC is required for any "Sub-standard" rating. Depending upon the egregious nature of the findings the IRC shall take appropriate sanction actions up to and including contract termination.

"Provisional" Approval Rating:
New DD service providers may qualify for a QMB "Provisional" Approval Rating upon successfully completing their initial QMB Quality Survey.
The QMB DD Manager will review the Report of Findings and determine if the provider has achieved at least a standard rating of approval. If successful, the provider may receive a one (1) year contract extension. QMB will notify the DDSD Contract unit of the "Provisional" approval rating.

Attachment C

Guidelines for the Provider
Informal Reconsideration of Finding (IRF) Process

Introduction:
Throughout the 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.

To informally dispute a finding the provider must request in writing an Informal Reconsideration of the Finding (IRF) to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.

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) and must specify in detail the request for reconsideration and why the finding is inaccurate. The **IRF request must include all supporting documentation or evidence that was not previously reviewed during the survey process.**

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received in 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 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 Scope and Severity of a finding.
- 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 Quality Approval Rating and the length of their DDSD provider contract.

A Provider forfeits the right to an IRF if the request is not made within 10 working days of receiving the report and 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 successfully reconsidered, it will be noted and will be removed or modified from the report. 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.

Administrative Review Process:
If a Provider desires to challenge the decision of the IRF committee they may request an Administrative Review by the DHI and DDSD Director. The Request must be made in writing to the QMB Bureau Chief and received within 5 days of notification from the IRF decision.

Regarding IRC Sanctions:
The Informal Reconsideration of the Finding process is a separate process specific to QMB Survey Findings and should not be confused with any process associated with IRC Sanctions.

If a Provider desires to Dispute or Appeal an IRC Sanction that is a separate and different process. Providers may choose the Informal Dispute Resolution Process or the Formal Medicaid Fair Hearing Process to dispute or appeal IRC sanctions, please refer to the DOH Sanction policy and section 39 of the provider contract agreement.

Agency: **Blue Sky Case Management, Inc. - Metro Region**
Program: Developmental Disabilities Waiver
Service: Case Management
Monitoring Type: Routine Survey
Date of Survey: **October 19 – 22, 2009**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A08 Agency Case File	**Scope and Severity Rating: C**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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. **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: (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,	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 18 of 22 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • **Current Emergency & Personal Identification Information** ° None Found (#22) ° Did not contain Physician phone number Information (#10) • **Annual ISP** ° Incomplete (#7) ° Not Current (#18) • **ISP Teaching & Support Strategies** ° Individual #8 - TASS not found ° Individual #10 - TASS not found ° Individual #18 - TASS not found ° Individual #22 - TASS not found • ISP Assessment Checklist (#6, 7, 10 & 22)	.	

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 developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (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 (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.	• ISP Signature Page (#7 & 18) • Addendum A (#7 & 18) • Individual Specific Training Section (ISP) (#7, 13 & 18) • Positive Behavioral Plan (#6) • Positive Behavioral Crisis Plan (#6, 7 & 12) • Speech Therapy Plan (#10, 12, &19) • Occupational Therapy Plan (#22) • Physical Therapy Plan (#1, 12 & 22) • Medication Administration Assessment Tool (#7 & 14) • **Health Care Plans** • Diabetes Individual #7 - As indicated by the IST section of ISP the individual is required to have a plan. ° Diabetes Individual #14 – As indicated by the IST section of the ISP the individual is required to have a plan. •Rectal Picking ° Individual #7 – According to documentation reviewed the individual us required to have a plan. •Dysphasia ° Individual #14 - As indicated by the IST section of ISP the individual is required to have a plan. •Neuropathy ° Individual #14 – According to documentation review the individual is required to have a plan.		

	• Hypertension ° Individual #14 - As indicated by the IST section of ISP the individual is required to have a plan. • COPD/Oxygen ° Individual #14 - As indicated by the IST section of ISP the individual is required to have a plan. • Psychotropic Medications ° Individual #14 – According to documentation reviewed the individual is required to have a plan. • Hyperlipdemia ° Individual #14 – According to documentation reviewed the individual is required to have a plan. • Depression ° Individual #14 - According to documentation reviewed the individual is required to have a plan. • Congestive Heart Failure ° Individual #14 - As indicated by the IST section of ISP the individual is required to have a plan • GERD ° Individual #14 - As indicated by the IST section of ISP the individual is required to have a plan • Constipation ° Individual #16 – According to documentation reviewed the individual is required to have a plan. • Fluid Volume Imbalance ° Individual #16 – According to documentation reviewed the individual is required to have a plan		

	• Health maintenance ° Individual #19 – According to documentation reviewed the individual is required to have a plan. • Seizures ° Individual #14 - As indicated by the IST section of ISP the individual is required to have a plan ° Individual #19 - As indicated by the IST section of ISP the individual is required to have a plan • Cardiac Problems ° Individual #20 - As indicated by the IST section of ISP the individual is required to have a plan • **Crisis Plans** • Allergies ° Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #22 - As indicated by the IST section of ISP the individual is required to have a plan. • Seizures ° Individual #7 - As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #14 - As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #16 - As indicated by the IST section of ISP the individual is required to have a plan. • Cardiac Condition ° Individual #14 - As indicated by the IST section of ISP the individual is required to have a plan. • Respiratory/Asthma ° Individual #14 - As indicated by the IST section		

	of ISP the individual is required to have a plan. • Diabetes ° Individual #14 - As indicated by the IST section of ISP the individual is required to have a plan. • Refusal of Medication ° Individual #14 – According to documentation reviewed the individual is required to have a plan. • Respiratory Distress/Obstruction ° Individual #16 - As indicated by the IST section of ISP the individual is required to have a plan. • High Risk For Infection ° Individual #16 – According to documentation reviewed the individual is required to have a plan. • Rectal Picking ° Individual #17 – According to documentation reviewed the individual is required to have a plan. • Sleep Apnea ° Individual #17 - As indicated by the IST section of ISP the individual is required to have a plan. • Depression ° Individual #17 – According to documentation reviewed the individual is required to have a plan. • Tube Feeding Protocol ° Individual #22 - As indicated by the IST section of ISP the individual is required to have a plan. • **Special Health Care Needs:** • Nutritional Plan ° Individual #14 - As indicated by the IST section		

	of ISP the individual is required to have a plan. ° Individual #17- As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #19 - As indicated by the IST section of ISP the individual is required to have a plan. ° Individual #22- As indicated by the IST section of ISP the individual is required to have a plan. **Other Individual Specific Evaluations & Examinations:** • **Dental Exam** ○ Individual #3 - As indicated by the documentation reviewed, exam was completed on 2/11/08. Follow-up was to be completed in 12 months. No evidence of follow-up found. ○ Individual #5 - As indicated by the documentation reviewed, exam was completed on 5/14/09. Follow-up was to be completed in 3 months. No evidence of follow-up found. ○ Individual #6 - As indicated by the documentation reviewed, exam was completed on 7/30/08. Follow-up was to be completed in 12 months. No evidence of follow-up found. ○ Individual #10 - As indicated by the documentation reviewed, exam was completed on 6/9/08. Follow-up was to be completed in 6 months. No evidence of follow-up found. ○ Individual #13 - As indicated by the documentation reviewed, exam was completed on 3/9/09. Follow-up was to be completed in 6 months. No evidence of follow-up found. ○ Individual #14- As indicated per ISP assessment page, exam was recommended.		

	No evidence to verify exam was scheduled or completed. ○ Individual #16 - As indicated by the documentation reviewed, exam was scheduled for 1/2009. No evidence found to verify exam was completed. ○ Individual #19 - As indicated by the documentation reviewed, exam was completed on 7/17/08. Follow-up was to be completed in 12 months. No evidence of follow-up found. ○ Individual #21 - As indicated by the documentation reviewed, exam was completed on 10/7/09. No evidence of exam was found. • **Auditory Exam** ○ Individual #8 - As indicated by the documentation reviewed, exam was completed on 8/20/08. Follow-up was to be completed in 12 months. No evidence of follow-up found. ○ Individual #14 - As indicated by the documentation reviewed, exam was completed on 5/2/08. Follow-up was to be completed in 12 months. No evidence of follow-up found ○ Individual #19 - As indicated by the documentation reviewed, exam was completed 9/09. No evidence of exam was found. ○ Individual #21 - As indicated by the documentation reviewed, exam was completed on 7/10/09. No evidence of exam was found. • **Vision Exam** ° Individual #1 - As indicated by the documentation reviewed, the exam was due on 8/11/09. No evidence of exam was found. ° Individual # 3- As indicated by the		

	documentation reviewed, the exam was due 2/4/09. No evidence of exam was found. • **Mammogram Exam** ° Individual #17 - As indicated by the documentation reviewed, exam was recommended on 8/31/09. No evidence found to verify visit was completed. ° Individual #21 - As indicated by the documentation reviewed, the exam was completed on 8/6/09. No evidence of exam was found. • **Pap Smear Exam** ° Individual #3 - As indicated by the documentation reviewed, exam was completed on 9/17/07. Follow-up was to be completed in 12 months. No evidence of follow-up found. • **Colonoscopy** ° Individual #14 - Per Doctor's order, exam to be completed on 9/22/2009. No evidence of exam found. • **Neurological Evaluation** ° Individual #14 - Per documentation reviewed, individual is required to have an evaluation. No evidence of evaluation was found. • **Psychiatric Evaluation** ° Individual # 14 - Per documentation reviewed, exam was completed 2/24/09. Recommendation stated a follow-up was to be completed on 7/14/09. No evidence found verifying follow-up was completed ° Individual #19 - Per documentation reviewed, exam was completed on 11/10/2008. Recommendation stated a follow-up was to be completed every 3 months. No evidence found verifying follow-up up was completed.		

	• **Nutritional Evaluation (#22)** ° Individual #22 - Per documentation reviewed individual is required to have an evaluation. No evidence of evaluation was found. • Vocational Assessment (#7 & 18) • Career Development Plan (#2 & 18) • Speech/Language Therapy Evaluation (#12 & 19) • Occupational Therapy Evaluation (#12) • Physical Therapy Evaluation (#1, 12 & 22)		

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: D		
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **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. **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. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007** **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.	Based on record review the Agency failed to provide documentation verifying completion of Incident Management Training for 1 of 4 Agency Personnel. • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#42)		

Tag # 1A37 Individual Specific Training - Case Manager Awareness Level	Scope and Severity Rating: B		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Case Management Agency Staff Policy - **Eff. March 1, 2007** **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified case managers. B. Case management 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. C. Case management staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. D. In addition to the applicable requirements described in policy statements B – C (above), case managers and case management supervisors shall complete DDSD-approved core curriculum training... E. Substitutes shall comply with the training requirements of the staff for whom they are substituting. F. To complete a core curriculum-training course, trainees shall achieve 100% competency rating during the competency verification process.	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 3 of 4 Agency Personnel. Review of personnel records found no evidence of the following: • Individual Specific Training (Awareness Level) (Case Manager #40, 41, & 43)		

Tag # 4C04 (CoP) - Assessment Activities	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS** **B. Case Management Assessment Activities:** Assessment activities shall include but are not limited to the following requirements: (1) Complete and compile the elements of the Long Term Care Assessment Abstract (LTCAA) packet to include: (a) LTCAA form (MAD 378); (b) Comprehensive Individual Assessment (CIA); (c) Current physical exam and medical/clinical history; (d) Norm-referenced adaptive behavioral assessment; and (e) A copy of the Allocation Letter (initial submission only). (2) Prior to service delivery, obtain a copy of the Medical Assistant Worker (MAW) letter to verify that the county Income Support Division (ISD) office of the Human Services Department (HSD) has completed a determination that the individual meets financial and medical eligibility to participate in the DD Waiver program. (3) Provide a copy of the MAW letter to service providers listed on the ISP budget (MAD 046).	Based on record review, the Agency failed to complete and compile the elements of the Long Term Care Assessment Abstract (LTCAA) packet for 2 of 22 individuals The following items were not found and/or incomplete: • Annual Physical (#4 & 16)		

Tag # 4C09 - Secondary FOC	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS** **G. Secondary Freedom of Choice Process** (1) The Case Management Provider Agency will ensure that it maintains a current Secondary Freedom of Choice (FOC) form that includes all service providers offering services in that region. (2) The Case Manager will present the Secondary FOC form to the individual or authorized representative for selection of direct service providers. (3) At least annually, at the time rights and responsibilities are reviewed, individuals and guardians served will be reminded that they may change providers at any time, as well as change types of services. At this time, Case Managers shall offer to review the current Secondary FOC list with individuals and guardians served. If they are interested in changing, a new FOC shall be completed.	Based on record review, the Agency failed to maintain current Secondary Freedom of Choice documentation and ensure individuals obtained all services through the Freedom of Choice Process for 4 of 22 individuals. The following items were not found and/or not agency specific to the individual's current services : • **Secondary Freedom of Choice** ° Behavior Support Consultant (#6) ° Occupational Therapy (#22) ° Physical Therapy (#22) ° Goods and Services (#21) ° Non-medical Transportation (#18)		

Tag # 4C12 (CoP) - Monitoring & Evaluation of Services	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS** **J. Case Manager Monitoring and Evaluation of Service Delivery** (1) The Case Manager shall use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual as specified in the ISP. (2) Monitoring and evaluation activities shall include, but not be limited to: (a) Face-To-Face Contact: A minimum of twelve (12) face-to-face contact visits annually (1 per month) is required to occur between the Case Manager and the individual served as described in the ISP; an exception is that children may receive a minimum of four visits per year; (b) Jackson Class members require two (2) face-to–face contacts per month, one of which occurs at a location in which the individual spends the majority of the day (i.e., place of employment, habilitation program) and one at the person's residence; (c) For non-Jackson Class members who receive Community Living Services, at least every other month, one of the face-to-face visits shall occur in the individual's residence; (d) For adults who are not Jackson Class members and who do not receive Community Living Services, at least one face-to-face visit per quarter shall be in his or her home;	Based on record review, the Agency failed to use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual for 5 of 22 individuals. **Record review of Agency files found face-to-face visits were NOT ALTERNATING between Community Sites and Residence Sites as required by standard for the following individuals:** Individual # 2 (Non – Jackson) • Two community site visits noted between 10/2008 & 6/2009. ° 10/17/08 - HV ° 11/20/08 - HV ° 12/04/08 - SV ° 12/17/08 - HV ° 1/12/09 - HV ° 2/23/09 - HV ° 3/19/09 - HV ° 4/2/09 - HV ° 5/18/09 - HV ° 6/30/09 - SV ° 6/15/09 - HV Individual#10 (Non-Jackson) • One community site visit noted between 10/2008 & 6/2009 ° 10/28/08- HV ° 11/19/08 – HV ° 12/16/08 – HV ° 1/29/09 – HV ° 2/26/09 – HV ° 3/24/09 – HV ° 4/15/09 – SV ° 5/28/09 – HV ° 6/11/09 – HV		

(e) If concerns regarding the health or safety of the individual are documented during monitoring or assessment activities, the Case Manager shall immediately notify appropriate supervisory personnel within the Provider Agency and document the concern. If the reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office and/or the Division of Health Improvement (DHI) as appropriate to the nature of the concern. Unless the nature of the concern is urgent, no more than fifteen (15) working days shall be allowed for remediation or development of an acceptable plan of remediation. This does not preclude the Case Managers' obligation to report abuse, neglect or exploitation as required by New Mexico Statute. (f) Service monitoring for children: When a parent chooses fewer than twelve (12) annual units of case management, the Case Manager will inform the parent of the parent's responsibility for the monitoring and evaluation activities during the months he or she does not receive case management services, (g) It is appropriate to conduct face-to-face visits with the individual both during the time the individual is receiving a service and during times the individual is not receiving a service. The preferences of the individual shall be taken into consideration when scheduling a visit. Visits may be scheduled in advance or be unannounced visits depending on the nature of the need in monitoring service delivery for the individual.	Individual #14 (Non – Jackson) • Two community site visits noted between 10/2008 & 6/2009. ° 10/6/08 – HV ° 11/07/08 – HV ° 12/30/08 – HV ° 1/27/09 – HV ° 2/26/09 – HV ° 3/26/09 – HV ° 4/17/09 – SV ° 5/27/09 – HV ° 6/18/09 – HV Individual #17 (Non – Jackson) • One community site visit noted between 9/2008 & 8/2009. ° 9/27/09 – HV ° 10/23/08 – HV ° 11/5/08 – HV ° 12/29/08 – HV ° 1/3/09 – HV ° 2/9/09 – SV ° 3/13/09 – HV ° 4/7/09 – HV ° 5/27/09 HV ° 6/8/09 – HV ° 7/1/09 – HV ° 8/31/09 – HV Individual #21 (Non – Jackson) • No community site visits noted between 10/2008 & 8/2009. ° 10/28/08 – HV ° 11/11/08 – HV ° 12/01/08 – HV ° 1/08/09 – HV ° 2/10/09 – HV ° 3/10/09 – HV ° 4/29/09 – HV		

(h) Communication with IDT members: Case Managers shall facilitate and maintain communication with the individual or his or her representative, other IDT members, providers and other relevant parties to ensure the individual receives maximum benefit of his or her services. Case Managers need to ensure that any needed adjustments to the service plan are made, where indicated. Concerns identified through communication with teams that are not remedied within a reasonable period of time shall be reported in writing to the respective regional office and/or the Division of Health Improvements, as appropriate to the concerns.	° 5/20/09 – HV ° 6/30/09 – HV ° 7/28/09 – HV ° 8/3/09 - HV		

Tag # 4C15 - QA Requirements - Bi-Annual Reports & Provider Quarterly Reports	Scope and Severity Rating: B		
CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS **C. Quality Assurance Requirements:** Case Management Provider Agencies will use an Internal Quality Assurance and Improvement Plan that must be submitted to and reviewed by the Statewide Case Management Coordinator, that shall include but is not limited to the following: (1) Case Management Provider Agencies are to: (a) Use a formal ongoing monitoring protocol that provides for the evaluation of quality, effectiveness and continued need for services and supports provided to the individual. This protocol shall be written and its implementation documented. (b) Assure that reports and ISPs meet required timelines and include required content. (c) Conduct a quarterly review of progress reports from service providers to verify that the individual's desired outcomes and action plans remain appropriate and realistic. (i) If the service providers' quarterly reports are not received by the Case Management Provider Agency within fourteen (14) days following the end of the quarter, the Case Management Provider Agency is to contact the service provider in writing requesting the report within one week from that date. (ii) If the quarterly report is not received within one week of the written request, the Case Management Provider Agency is to contact the respective DDSD Regional Office in writing within one business day for assistance in obtaining required reports. (d) Assure at least quarterly that Crisis Prevention/Intervention Plans are in place in	Based on record review, the Agency failed to ensure that reports and ISP's meet required timelines and include the required contents for 13 of 22 individuals. The following quarterly/bi-annual reports were not found: • **Supported Living Quarterly Reports:** ° Individual #6 – None found for July 2009 - September 2009. ° Individual #10 – None found for June 2009 - August 2009. ° Individual #14 – None found for September 2008 - November 2008; February 2009 & June 2009 - July 2009. ° Individual #16 – None found for February 2009 - April 2009. ° Individual #19 – None found for July 2009 - September 2009. ° Individual #22 – None found for August 2009 & September 2009. • **Community Inclusion - Adult Habilitation Quarterly Reports:** ° Individual #10 – None found for August 2008 - October 2008. ° Individual #11 – None found for August 2008 - April 2009. ° Individual #14 – None found for November and December 2008. (Note: Agency completes Monthly Reports		

the residence and at the Provider Agency of the Day Services for all individuals who have chronic medical condition(s) with potential for life threatening complications and/or who have behavioral challenge(s) that pose a potential for harm to themselves or others. (e) Assure at least quarterly that a current Health Care Plan (HCP) is in place in the residence and day service site for individuals who receive Community Living or Day Services and who have a HAT score of 4, 5, or 6. During face-to-face visits and review of quarterly reports, the Case Manager is required to verify that the Health Care Plan is being implemented. (f) Assure that Community Living Services are delivered in accordance with standards, including responsibility of the IDT Members to plan for at least 30 hours per week of planned activities outside the residence. If this is not possible due to the needs of the individual, a goal shall be developed that focuses on appropriate levels of community integration. These activities do not need to be limited to paid supports but may include independent or leisure activities appropriate to the individual. (g) Perform annual satisfaction surveys with individuals regarding case management services. A copy of the summary is due each December 10th to the respective DDSD Regional Office, along with a description of actions taken to address suggestions and problems identified in the survey. (h) Maintain regular communication with all providers delivering services and products to the individual. (i) Establish and implement a written grievance procedure.	° Individual #20 – None found for July 2009 - September 2009. • **Community Inclusion - Supported Employment Quarterly Reports:** ° Individual #2 – None found for December 2008 - February 2009. • **Positive Behavior Consultation Quarterly Reports:** ° Individual #10 – None found for 6/2009 - 8/2009. ° Individual #14 – None found for 4/2009 - 9/2009. ° Individual #17 – None found for July 2009 - September 2009. ° Individual #18 – None found for July 2009 - September 2009. ° Individual #19 – None found for June 2009 - August 2009. ° Individual #22 – None found for September 2008 - December 2008 and June 2009 - August 2009. • **Occupational Bi-Annual Progress Reports:** ° Individual #1 – None found for January 2009 - June 2009. ° Individual #12 – None found for January 2009 - June 2009. • **Speech & Language Pathology Bi-Annual Progress Reports:** ° Individual #10 – None found for April 2008 - October 2008.		

(j) Notify appropriate supervisory personnel within the Provider Agency if concerns are noted during monitoring or assessment activities related to any of the above requirements. If such concerns are not remedied by the Provider Agency within a reasonable mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office and/or DHI as appropriate to the nature of the concern. This does not preclude Case Managers' obligations to report abuse, neglect or exploitation as required by New Mexico Statute. (k) Utilize and submit the "Request for DDSD Regional Office Intervention" form as needed, such as when providers are not responsive in addressing a quality assurance concern. The Case Management Provider Agency is required to keep a copy in the individual's file. (2) Case Managers and Case Management Provider Agencies are required to promote and comply with the Case Management Code of Ethics: (a) Case Managers shall provide the individual/guardian with a copy of the Code of Ethics when Addendum A is signed. (b) Complaints against a Case Manager for violation of the Code of Ethics brought to the attention of DDSD will be sent to the Case Manager's supervisor who is required to respond within 10 working days to DDSD with detailed actions taken. DDSD reserves the right to forward such complaints to the IRC.	° Individual #19 – None found for March 2009 - August 2009.		

ADDITIONAL FINDINGS: Reimbursement Deficiencies

BILLING
TAG #1A12

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION**

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:

(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.

Billing for Case Management services was reviewed for 22 of 22 individuals. Progress notes and billing records supported billing activities for the months of July, August, and September 2009.