Date:	July 13, 2009
To:	Gabriela B. Ramos, Executive Director
Provider:	Carino Case Management
Address:	2710 San Pedro NE #10
State/Zip:	Albuquerque, New Mexico 87110
CC:	Patricia R. Schifani, Board Chair
Address:	12228 Woodland, NE
State/Zip	Albuquerque, New Mexico 87111
E-mail Address:	gbramos@comcast.net
Region:	Metro
Survey Date:	June 22 - 24, 2009
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Case Management
Survey Type:	Routine
Team Leader:	Crystal Lopez-Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Tony Fragua, BFA, Healthcare Surveyor Division of Health Improvement/Quality Management Bureau; Cynthia Nielsen, RN, Healthcare Surveyor Division of Health Improvement/Quality Management Bureau & Florie Alire, RN, Healthcare Surveyor Division of Health Improvement/Quality Management Bureau
Survey #:	Q09.04.D2326.METRO.001.RTN.01

Dear Ms. Ramos,

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 granting your agency a “STANDARD” certification for basic 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 900 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 #900
Albuquerque, NM 87108
Attention: IRF request

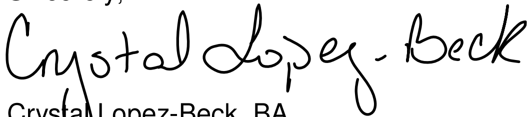
A request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 working days. Providers may not appeal the nature or interpretation of the standard or regulation, the team composition, sampling methodology or the Scope and Severity of the finding.

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 505-222-6625, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,



Crystal Lopez-Beck, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	June 22, 2009	
Present:	**Carino Case Management** Gabriela B. Ramos, Executive Director/Case Manager Supervisor Patricia R. Schifani, Case Manager **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Cynthia Nielsen, RN, Healthcare Surveyor	
Exit Conference Date:	June 24, 2009	
Present:	**Carino Case Management** Gabriela B. Ramos, Executive Director/Case Manager Supervisor Linda E. Boddy, Case Manager Jo Brewer, Case Manager Patricia R. Schifani, Case Manager **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor Cynthia Nielsen, RN, Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	21 3 - Jackson Class Members 18 - Non Jackson Class Members
Case Managers Interviewed	Number:	9
Records Reviewed (Persons Served)	Number:	21

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 505-222-8624.
- 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 (505-841-5815), 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 505-222-8624 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.

<table>
<tr><td colspan="3"></td><th colspan="3">SCOPE</th></tr>
<tr><th rowspan="6">SEVERITY</th><td></td><td></td><th>Isolated
01% - 15%</th><th>Pattern
16% - 79%</th><th>Widespread
80% - 100%</th></tr>
<tr><th rowspan="2">High Impact</th><td>Immediate Jeopardy to individual health and or safety</td><td>J.</td><td>K.</td><td>L.</td></tr>
<tr><td>Actual harm</td><td>G.</td><td>H.</td><td>I.</td></tr>
<tr><th rowspan="2">Medium Impact</th><td rowspan="2">No Actual Harm Potential for more than minimal harm</td><td>D.</td><td rowspan="2">E.</td><td>F. (3 or more)</td></tr>
<tr><td>D. (2 or less)</td><td>F. (no conditions of participation)</td></tr>
<tr><th>Low Impact</th><td>No Actual Harm Minimal potential for harm.</td><td>A.</td><td>B.</td><td>C.</td></tr>
</table>

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.

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) 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: **Carino Case Management – Metro Region**
Program: Developmental Disabilities Waiver
Service: Case Management
Monitoring Type: Routine
Date of Survey: **June 22 - 24, 2009**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A05 (CoP) General Requirements	**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. **A. General Requirements:** (2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.	Based on record review, the Agency failed to review and update its written policies and procedures every three years or as needed. The following polices and procedures provided during the on-site survey (June 22 - 24, 2009) showed no evidence of being reviewed every three years: • "Grievance"- Last reviewed and/or revised 10/2003.		

Tag # 1A08 Agency Case File	Scope and Severity Rating: B		
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, 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	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 10 of 21 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Teaching & Support Strategies (#4 & 9) • Positive Behavioral Crisis Plan (#16) • Speech Therapy Plan (#7) • Occupational Therapy Plan (#3) • Physical Therapy Plan (#3) • **Crisis Plans** • Cardiac Condition ° Individual #1 - As indicated by the Individual Specific Training Section of the ISP a crisis plan is required. ° Individual #3 - As indicated by the Individual Specific Training Section of the ISP a crisis plan is required. • GERD ° Individual #2 - As indicated by the Individual Specific Training Section of the ISP a crisis plan is required. • Allergies ° Individual #2 - As indicated by the Individual Specific Training Section of the ISP a crisis plan is required. • Asthma ° Individual #9 - As indicated by the Individual Specific Training Section 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 a crisis plan is required. • Skin Breakdown ° Individual #19 - As indicated by the Individual Specific Training Section of the ISP a crisis plan is required. • **Special Health Care Needs** ° Nutritional Plan ° Individual #9 - As indicated by the Individual Specific Training Section of the ISP a crisis plan is required. • **Vision Exam** ° Per documentation reviewed, exam was completed on 4/27/2009. No evidence of exam found. (Individual #4) ° Per documentation reviewed, last exam was completed on 2/15/2008. Recommendation stated to follow-up yearly. No evidence found verifying follow-up was completed. (Individual #12) • **Bone Density** ° Per documentation reviewed, exam was completed on 4/9/2007. No evidence was of exam found. (Individual #4) • **Blood Levels** ° Per documentation reviewed, last exam was completed in 5/2008. Recommendation stated to follow-up in 4/2009. No evidence found verifying follow-up was completed. (Individual #9) • **Psychiatric Evaluation** ° Per documentation reviewed, exam was completed on 1/15/2009. Recommendation stated to follow-up every 3 months. No evidence found verifying follow-up up was completed. (Individual #4)		

	• **Neurological Evaluation** ° Per documentation reviewed, exam was completed on 3/14/1997. No evidence of exam found. (#6) • Occupational Therapy Evaluation (#2) • Physical Therapy Evaluation (#3) • Speech/Language Therapy Evaluation (#7)		

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: E		
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. **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. **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	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 2 of 9 Agency Personnel. The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings: • #40 – Date of hire 10/09/2002 • #44 – Date of hire 1/1/2007		

H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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.			

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: D		
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. 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. 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. 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.	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 1 of 9 Agency Personnel. The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire: • #44 – Date of Hire 1/1/2007		

E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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.			

Tag #1A40 - Provider Requirement Accreditation	Scope and Severity Rating: C		
NMAC 7.26.6.6 OBJECTIVE: A. These regulations are being promulgated to promote and assure the provision of quality services to persons with developmental disabilities residing in community agencies. B. These regulations are being promulgated as part of a quality assurance initiative requiring all community agencies providing services to persons with developmental disabilities and contracting with the developmental disabilities division to be accredited by the commission on accreditation of rehabilitation facilities (CARF). **7.26.6.14 CARF STANDARDS MANUAL FOR ORGANIZATIONS SERVING PEOPLE WITH DEVELOPMENTAL DISABILITIES:** Community agencies governed by these regulations are required to meet applicable provisions of the most current edition of the "CARF Standards Manual for Organizations Serving People with Disabilities". Sections of the CARF standards may be waived by the Department when deemed not applicable to the services provided by the community agency. **Long Term Services Division Policy -** Accreditation of Long Term Services Division Funded Providers eff. August 30, 2004 **A. Mandate for Accreditation** The Department of Health, Long Term Services Division (hereafter referred to as the Division) will contract only with agencies/organizations accredited in compliance with this policy. 1. Within eighteen (18) months of an initial contract or change in exemption status as defined in this policy, the contractor must provide the Division with written verification of accreditation from the	Based on observation and interview, the Agency failed to obtain the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (The Council) accreditation or the applicable waiver from the Developmental Disability Support Division. When #48 was asked if the Agency had evidence of current CARF accreditation or a waiver from DDSD the following was reported: #48 stated, "Our CARF accreditation expired in 2007 and I have never requested the waiver from DDSD. I know that is supposed to be done and it has been requested now."		

Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (The Council). 2. Except as provided in this policy, the Division may terminate its contract with a contractor that fails to maintain an accreditation status of at least one year, regardless of any appeal process available from CARF or the Council.			

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 1 of 21 individuals. The following items were not found, incomplete and/or not current: • MAW Letter (#9)		

Tag # 4C09 - Secondary FOC	Scope and Severity Rating: A		
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 documentation assuring individuals obtained all services through the Secondary Freedom of Choice process for 1 of 21 individuals. No evidence was found of the following: • Secondary Freedom of Choice ° Physical Therapy (#3)		

Tag # 4C12 (CoP) - Monitoring & Eval. of Serv.	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; (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	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 7 of 21 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 #1 (Non-Jackson) One community site visits noted between 6/2008 & 5/2009. • 6/23/08 – HV • 7/15/08 – HV • 8/4/08 – ISP • 9/30/08 – HV • 10/28/08 – HV • 11/07/08 – SV • 12/23/08 – HV • 1/29/09 – HV • 2/10/09 – HV • 3/17/09 – HV • 4/29/09 - HV • 5/26/09 – HV Individual #9 (Jackson) Four community site visits noted between 6/2008 & 5/2009. • 6/2/08 – HV • 6/25/08 – HV • 7/1/08 – HV • 7/22/08 – HV • 8/5/08 – HV • 8/26/08 – HV • 9/2/08 – HV • 9/23/08 – SV • 10/7/08 – HV • 10/16/08 – SV		

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. (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.	• 11/4/08 – HV • 11/24/08 – IDT • 12/2/08 – HV • 12/17/08 – SV • 1/6/09 – HV • 1/20/09 – SV • 2/10/09 – HV • 2/23/09 – HV • 3/2/09 – HV • 3/12/09 – HV • 4/7/09 – HV • 4/20/09 – IDT • 5/5/09 – HV • 5/28/09 – ISP Individual #11 (Non-Jackson) No community site visits noted between 6/2008 & 5/2009. • 6/6/08 – 11:30am - 12:30pm - HV • 7/18/08 – 11am - 12:30pm - HV • 8/1/08 – 11:30am - 12:30pm - HV • 9/5/08 – 11:15am -12:15pm - HV • 10/17/08 – ISP • 11/7/08 – 11:30am - 12:30pm – HV • 12/5/08 – 11:30am - 12:30pm – HV • 1/9/09 – 11:30am - 12:30pm – HV • 2/6/09 – 11:30am - 12:30pm – HV • 3/6/09 – 11:30am - 12:30pm – HV • 4/3/09 – 10am – 12pm – HV • 5/1/09 – 11:30am -12:30pm – HV Individual #14 (Non-Jackson) Two community site visits noted between 6/2008 & 5/2009. • 6/16/08 – HV • 7/14/08 – SV • 8/12/08 – HV • 9/23/08 – SV • 10/15/08 – HV • 11/10/08 – HV • 12/11/08 – HV		

	• 1/19/09 – HV • 2/5/09 – ISP • 3/11/09 – HV • 4/9/09 – HV • 5/11/09 – HV Individual #15 (Non-Jackson) No community site visits between 6/2008 & 5/2009. • 6/30/08 – no time of visit indicated on case manager's notes – HV • 7/30/08 – no time of visit indicated on case manager's notes – HV • 8/29/08 – no time of visit indicated on case manager's notes – HV • 9/29/08 – no time of visit indicated on case manager's notes – HV • 10/24/08 – 12pm – 1pm – HV • 11/12/08 – 12pm - 1:30pm – HV • 12/17/08 – 12pm - 1:30pm– HV • 1/27/09 – 11:30am - 12:30pm – HV • 2/23/09 – 10am - 12:30pm – ISP • 3/16/09 – 11:30am - 1:30pm – HV • 4/30/09 – 11:30am - 12:30pm – HV • 5/26/09 11:30am - 12:50pm – HV Individual #16 (Non-Jackson) Two community site visits between 6/2008 & 5/2009. • 6/27/08 – HV • 7/25/08 – HV • 8/25/08 – HV • 9/22/08 – HV • 10/21/08 – ISP • 11/6/08 – IEP • 12/11/08 – HV • 1/27/09 – HV • 2/27/09 – HV • 3/23/09 – HV • 4/23/09 – HV • 5/5/09 – IEP		

	Individual #19 (Non-Jackson) One community site visit noted between 6/2008 & 5/2009. • 6/6/08 – HV • 7/18/08 – SV • 8/13/08 – HV • 9/17/08 – HV • 10/22/08 – HV • 11/13/08 – HV • 12/17/08 – HV • 1/16/09 – HV • 2/19/09 – HV • 3/13/09 – HV • 4/10/09 – HV • 5/21/09 – HV		

Tag # 4C16 (CoP) - Req. for Reports & Distribution of Doc.	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS** **D. Case Manager Requirements for Reports and Distribution of Documents** (1) Case Managers will provide reports and data as specified/requested by DDSD within the required time frames. **(2) Case Managers shall provide copies of the ISP to the Provider Agencies listed in the budget, and the individual and guardian (if applicable) within 14 days of ISP approval;** (3) Case Managers shall provide copies of the ISP to the respective DDSD Regional Offices within 14 days of ISP approval. (4) Copies of the ISP given to providers, the individual and guardians shall include any related ISP minutes, provider strategies, individual specific training required, client rights and responsibilities, and revisions, if applicable. (5) At times, recommendations for further evaluations, screenings, diagnostics and/or treatments may be made to the IDT Members by various healthcare staff, consultants, various audit tools, the Supports and Assessments for Feeding and Eating (SAFE) Clinic, Transdisciplinary Evaluation and Support Clinic (TEASC) or other experts: (a) The IDT Members shall discuss these recommendations and a determination made if the IDT Members agree with the recommendations. (b) If the IDT Members concur with the recommendation, the ISP is required to be revised and follow-up shall be completed and documented in progress reports and, if applicable, in a revision to relevant therapy plans. (c) If the IDT Members, in their professional	Based on record review, the Agency failed to ensure that reports and ISPs meet required timelines and include the required contents for 1 of 21 individuals. Evidence of the following quarterly/bi-annual reports were not found: • **Supported Living Quarterly Reports:** ° Individual #4 – None found for 7/2008; 4/2009 & 05/2009 (Agency reports are done monthly) • **Community Inclusion (Adult Habilitation) Quarterly Reports:** ° Individual #4 – None found for 4/2009 & 5/2009 (Agency reports are done monthly)		

judgment, do not agree with the recommendation, the reasons for this shall be clearly documented in the Decision Justification document and filed by the Case Manager with the healthcare provider or consultant report/document in which the recommendation was made. (d) A copy of the Decision Justification document shall also is given to the residential provider (if any) and the guardian. (6) The individual's name and the date are required to be included on all pages of documents. All documents shall also include the signature of the author on the last page.			

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 21 of 21 individuals. Progress notes and billing records supported billing activities for the months of March, April & May 2009.