

SUSANA MARTINEZ, GOVERNOR

CATHERINE D. TORRES, M.D., CABINET SECRETARY

Date: February 29, 2012

To: DeAnn Fierro, Executive Director  
Provider: Excel Case Management, Inc.  
Address: 626 E. Main St.  
State/Zip: Farmington, NM 87401

E-mail Address: [dfierro@excelcasemanagement.com](mailto:dfierro@excelcasemanagement.com)

CC: Dave Dunaway, Board Chair  
Address: 804 W. 24<sup>th</sup> St.  
State/Zip: Farmington, NM 87401

Region: Northwest  
Survey Date: February 6 - 8, 2012  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Case Management  
Survey Type: Routine  
Team Leader: Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Maurice Gonzales, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Fierro;

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

**Determination of Compliance:**

The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

***Compliance with all Conditions of Participation.***

This determination is based on your agency's compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.



**DIVISION OF HEALTH IMPROVEMENT • QUALITY MANAGEMENT BUREAU**  
5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108  
(505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

QMB Report of Findings – Excel Case Management Inc. – Northwest Region – February 6 - 8, 2012

Survey Report #: Q12.03.D3826.NW.001.RTN.01

**Plan of Correction:**

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

**Submission of your Plan of Correction:**

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

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

- 1. Quality Management Bureau, Attention: 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 to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

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

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

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

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator at 505-222-8647 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

*Erica Nilsen, BA*

Erica Nilsen, BA  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: February 6, 2012

Present: **Excel Case Management, Inc.**  
DeAnn Fierro, Executive Director

**DOH/DHI/QMB**

Erica Nilsen, BA, Team Lead/Healthcare Surveyor  
Tony Fragua, BFA, Healthcare Surveyor  
Jennifer Bruns, BSW, Healthcare Surveyor  
Maurice Gonzales, BS, Healthcare Surveyor

Exit Conference Date: February 8, 2012

Present: **Excel Case Management, Inc.**  
DeAnn Fierro, Executive Director  
Diane Metoyer, Case Manager/Case Manager Supervisor

**DOH/DHI/QMB**

Erica Nilsen, BA, Team Lead/Healthcare Surveyor  
Tony Fragua, BFA, Healthcare Surveyor  
Jennifer Bruns, BSW, Healthcare Surveyor  
Maurice Gonzales, BS, Healthcare Surveyor

**DDSD – Northwest Regional Office**

Cathy Saxton, Northwest Regional Case Management Coordinator  
Crystal Wright, Northwest Regional Director (Via telephone)

Administrative Locations Visited Number: 1

Total Sample Size Number: 22  
4 - Jackson Class Members  
18 - Non-Jackson Class Members

Persons Served Records Reviewed Number: 22

Case Managers Interviewed Number: 8

Case Mgt Personnel Records Reviewed Number: 8

Administrative Files Reviewed

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

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

QMB Report of Findings – Excel Case Management Inc. – Northwest Region – February 6 - 8, 2012

Survey Report #: Q12.03.D3826.NW.001.RTN.01

## **Attachment A**

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

#### ***Introduction:***

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

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued non compliance.

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

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings. (Providers who fail to complete a POC within the 45 business days allowed shall be referred to the IRC for possible actions or sanctions.)

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

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

#### ***Instructions for Completing Agency POC:***

##### ***Required Content***

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

The Plan of Correction must address the required six CMS core elements to address ***each deficiency*** of the POC:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and

- sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
  6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your POC:

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Incident Reporting, and Individual-Specific service requirements, etc;
- How accuracy in Billing documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how ISPs are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

**Note: Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps should be taken to ensure the deficiency is corrected and will not recur.

#### **Completion Dates**

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

#### **Initial Submission of the Plan of Correction Requirements**

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
  - a. Electronically at [George.Perrault@state.nm.us](mailto:George.Perrault@state.nm.us) (*preferred method*)
  - b. Fax to 505-222-8661, or
  - c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the POC Coordinator.
6. QMB will notify you when your POC has been “approve” or “denied.”

- a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
  - b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
  - c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
  - d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

### ***POC Document Submission Requirements***

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. You may submit your documents by postal mail (paper hard copy or on a disc), fax, or electronically (scanned and attached to e-mails).
3. All submitted documents must be annotated; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. For billing deficiencies, you must submit:
  - a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
  - b. Copies of “void and adjust” forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

## QMB Determinations of Compliance

- “Compliance with Conditions of Participation”  
The QMB determination of “Compliance with Conditions of Participation,” indicates that a provider is in compliance with all ‘Conditions of Participation,’ (CoP) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals’ health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with *all* Conditions of Participation.
- “Partial-Compliance with Conditions of Participation”  
The QMB determination of “Partial-Compliance with Conditions of Participation” indicates that a provider is out of compliance with one (1) to three (3) ‘Conditions of Participation.’ This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety. The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

Providers receiving a repeat determination of ‘Partial-Compliance’ for repeat deficiencies of CoPs may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- “Non-Compliant with Conditions of Participation”:  
The QMB determination of “Non-Compliance with Conditions of Participation,” indicates a provider is significantly out of compliance with Conditions of Participation and/or has:
  - Four (4) Conditions of Participation out of compliance.
  - Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
  - Any finding of actual harm or Immediate Jeopardy.The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

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

## Attachment C

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

#### Introduction:

Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated "Document Request," or "administrative Needs," etc. forms. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

#### Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: <http://dhi.health.state.nm.us/qmb>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRC process, email the IRF Chairperson, Scott Good at [scott.good@state.nm.us](mailto:scott.good@state.nm.us) for assistance.

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

- The request for an IRF and all supporting evidence must be received within 10 business days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.
- Providers may not request an IRF to challenge the DHI/QMB determination of compliance or the length of their DDSD provider contract.

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

The IRF Committee will review the request, the Provider will be notified in writing of the ruling; no face-to-face meeting will be conducted.

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.



**Agency:** Excel Case Management, Inc. - Northwest Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Case Management  
**Monitoring Type:** Routine Survey  
**Date of Survey:** February 6 - 8, 2012

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p><b>CMS Assurance – Plan of Care - ISP Development &amp; Monitoring</b> – Service plans address all participants’ assessed needs(including health and safety risk factors) and goals, either by waiver services or through other means. Services plans are updated or revised at least annually or when warranted by changes in the waiver participants’ needs.</p>			
<p><b>Tag # 1A08 Agency Case File</b></p>	<p><b>Standard Level Deficiency</b></p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007  <b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.  <b>D. Provider Agency Case File for the Individual:</b> 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</p>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 16 of 22 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• <b>ISP Signature Page</b> <ul style="list-style-type: none"> <li>◦ None Found (#12)</li> </ul> </li> <li>• ISP Assessment Checklist (#7)</li> <li>• Addendum A (#21)</li> <li>• <b>ISP Teaching &amp; Support Strategies</b> <ul style="list-style-type: none"> <li>◦ Individual #7 - TASS not found for:               <ul style="list-style-type: none"> <li>◦ Outcome Statement - Relationships/Have Fun: “Socialize at Sammy C’s.”                   <ul style="list-style-type: none"> <li>➢ “...will plan to go to Sammy C.’s.”</li> <li>➢ “...will go to Sammy C.’s.”</li> </ul> </li> <li>◦ Outcome Statement - Relationships/Have</li> </ul> </li> </ul> </li> </ul>	<p><b>Provider:</b>            State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>requirements:</p> <ol style="list-style-type: none"> <li>(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;</li> <li>(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);</li> <li>(3) Progress notes and other service delivery documentation;</li> <li>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</li> <li>(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;</li> <li>(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</li> <li>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</li> <li>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: <ol style="list-style-type: none"> <li>(a) Complete file for the past 12 months;</li> <li>(b) ISP and quarterly reports from the current and prior ISP year;</li> <li>(c) Intake information from original admission to services; and</li> <li>(d) When applicable, the Individual Transition Plan at the time of discharge</li> </ol> </li> </ol>	<p>Fun: "...will attend 6 Native American dances."</p> <ul style="list-style-type: none"> <li>➤ "...will look for Native American dances."</li> <li>➤ "...will attend Native American dances."</li> </ul> <ul style="list-style-type: none"> <li>◦ <i>Individual #9 - TASS not found for:</i></li> <li>◦ Outcome Statement - Live Area: "Will travel to destination of choice." <ul style="list-style-type: none"> <li>➤ "...will research a trip with staff assistance."</li> <li>➤ "...Make arrangements for trip."</li> <li>➤ "...will go on a trip."</li> </ul> </li> </ul> <ul style="list-style-type: none"> <li>• Positive Behavioral Plan (#8 &amp;18)</li> <li>• Speech Therapy Plan (#10)</li> <li>• Occupational Therapy Plan (#5, 7, 13 &amp; 21)</li> <li>• Physical Therapy Plan (#1, 7, 14, 18 &amp; 21)</li> <li>• <b>Health Care Plans</b> <ul style="list-style-type: none"> <li>• <i>Aspiration</i> <ul style="list-style-type: none"> <li>◦ Individual #7 - As indicated by the Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is required to have a plan. No evidence of plan found.</li> <li>◦ Individual #12 - As indicated by the Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is required to have a plan. No evidence of plan found.</li> </ul> </li> <li>• <i>Oral Care</i> <ul style="list-style-type: none"> <li>◦ Individual #10 - As indicated by the Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is</li> </ul> </li> </ul> </li> </ul>		
--	---	--	--

<p>from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>	<p>required to have a plan. No evidence of plan found.</p> <ul style="list-style-type: none"> <li>• <i>Bowel/Bladder</i> <ul style="list-style-type: none"> <li>◦ Individual #12 - As indicated by the Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is required to have a plan. No evidence of plan found.</li> </ul> </li> <li>• <i>Body Mass Index</i> <ul style="list-style-type: none"> <li>◦ Individual #12 - As indicated by the Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is required to have a plan. No evidence of plan found.</li> </ul> </li> <li>• <i>Falls</i> <ul style="list-style-type: none"> <li>◦ Individual #12 - As indicated by the Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is required to have a plan. No evidence of plan found.</li> </ul> </li> <li>• <i>Oral Care/Hygiene</i> <ul style="list-style-type: none"> <li>◦ Individual #14 - As indicated by the Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is required to have a plan. No evidence of plan found.</li> </ul> </li> <li>• <i>Seizures</i> <ul style="list-style-type: none"> <li>◦ Individual #21 - As indicated by the Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is required to have a plan. No evidence of plan found.</li> </ul> </li> <li>• <i>GI (Constipation)</i> <ul style="list-style-type: none"> <li>◦ Individual #21 - As indicated by the</li> </ul> </li> </ul>		
---	---	--	--

	<p>Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is required to have a plan. No evidence of plan found.</p> <ul style="list-style-type: none"> <li>• <b>Crisis Plans/Medical Emergency Response Plans</b> <ul style="list-style-type: none"> <li>• <i>Aspiration</i> <ul style="list-style-type: none"> <li>◦ Individual #8 - As indicated by the Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is required to have a plan. No evidence of plan found.</li> <li>◦ Individual #12 - As indicated by the Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is required to have a plan. No evidence of plan found.</li> <li>◦ Individual #17 - As indicated by the Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is required to have a plan. No evidence of plan found.</li> <li>◦ Individual #21 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found</li> </ul> </li> <li>• <i>Cardiac</i> <ul style="list-style-type: none"> <li>◦ Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found.</li> </ul> </li> <li>• <i>Falls</i> <ul style="list-style-type: none"> <li>◦ Individual #12 - As indicated by the Electronic Comprehensive Health Assessment Tool (e-Chat) the individual is required to have a plan. No evidence of</li> </ul> </li> </ul> </li> </ul>		
--	---	--	--

	<p>plan found.</p> <ul style="list-style-type: none"> <li>• <i>GI (Constipation)</i> <ul style="list-style-type: none"> <li>◦ Individual #21 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found.</li> </ul> </li> <li>• <i>Mass on neck</i> <ul style="list-style-type: none"> <li>◦ Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found.</li> </ul> </li> <li>• <b>Nutritional Evaluation</b> <ul style="list-style-type: none"> <li>◦ Individual #13 - Per documentation reviewed evaluation was completed on 3/29/2007. Follow-up was to be completed in 1 month. No documented evidence of the evaluation being completed was found.</li> </ul> </li> <li>• <b>Dental Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #1 - As indicated by the DDS file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found.</li> <li>◦ Individual #3 - As indicated by the documentation reviewed, exam was completed on 6/21/2011. Follow-up was to be completed in 6 months. No documented evidence of the follow-up being completed was found.</li> <li>◦ Individual #4 - As indicated by the ISP Assessment Checklist, exam was due in January 2011. No documented evidence was found to verify visit was completed.</li> <li>◦ Individual #12 - As indicated by the DDS file matrix Dental Exams are to be conducted annually. No documented</li> </ul> </li> </ul>		
--	---	--	--

	<p>evidence of exam was found.</p> <ul style="list-style-type: none"> <li>• <b>Auditory Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #1 - As indicated by the documentation reviewed, exam was completed on 7/8/2010. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found.</li> </ul> </li> <li>• <b>Vision Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #17 - As indicated by the documentation reviewed, exam was completed on 12/8/2009. Follow-up was to be completed in 2 years. No documented evidence of the follow-up being completed was found.</li> </ul> </li> <li>• <b>Pap Smear Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #10 - As indicated by the documentation reviewed, exam was completed on 6/16/2010. Follow-up was to be completed in June 2011. No documented evidence of the follow-up being completed was found.</li> <li>◦ Individual #17 - As indicated by the documentation reviewed, the exam was completed on 7/27/2011. No documented evidence of the exam being completed was found.</li> </ul> </li> <li>• <b>Blood Levels</b> <ul style="list-style-type: none"> <li>◦ Individual #14 - As indicated by the documentation reviewed, the annual physical completed on 8/31/11 stated lab work was ordered. No documented evidence found to verify it was completed.</li> </ul> </li> </ul>		
--	--	--	--

- |  |  |  |  |
|--|--|--|--|
|  | <ul style="list-style-type: none"><li>• Vocational Assessment Profile (#11, 12 &amp; 13)</li><li>• Positive Behavior Support Assessment (#8)</li><li>• Occupational Therapy Evaluation (#5, 7, 13, 21 &amp; 22)</li><li>• Physical Therapy Evaluation (#1, 7 &amp; 18)</li></ul> |  |  |
|--|--|--|--|

Tag # 4C02 Scope of Services - Primary Freedom of Choice	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 4 II. SCOPE OF CASE MANAGEMENT SERVICES:</b> Case Management shall include, but is not limited to, the following services:</p> <p>T. Assure individuals obtain all services through the Freedom of Choice process.</p>	<p>Based on record review, the Agency failed to maintain documentation assuring individuals obtained all services through the freedom of choice process for 1 of 22 individuals.</p> <p>No evidence was found of the following:</p> <ul style="list-style-type: none"> <li>• Primary Freedom of Choice (#4)</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	



Tag # 4C08 ISP Development Process	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS - F. Case Manager ISP Development Process:</b></p> <p>(1) The Case Manager meets with the individual in advance of the ISP meeting in order to enable the person to review current assessment information, prepare for the meeting, plan to facilitate or co-facilitate the meeting if the individual wishes and to ensure greater and more informed participation.</p> <p>(2) The Case Manager will discuss and offer the optional Personal Plan Facilitation service to the individual to supplement the ISP planning process; if selected, the Case Manager will assist in obtaining this service through the FOC process. This service is funded within the individual's ARA.</p> <p>(3) The Case Manager convenes the IDT members and a service plan is developed in accordance with the rule governing ISP development (7.26.5 NMAC).</p> <p>(4) The Case Manager will advise the individual of his or her rights and responsibilities related to receipt of services, applicable federal and state laws and guidelines, DOH policies and procedures pertaining to the development and implementation of the ISP, confidentiality, abuse, neglect, exploitation, and appropriate grievance and appeal procedures. In addition, the Case Manager shall provide the individual and/or guardian with a copy of the Case Management Code of Ethics at this time.</p> <p>(5) The Case Manager will clarify the</p>	<p>Based on record review the Agency failed to ensure Case Managers provided and/or advised the individual and/or guardian with the following requirements for 1 of 22 individuals.</p> <p>Review of record found no evidence of the following:</p> <ul style="list-style-type: none"> <li>• Rights &amp; Responsibilities (#21)</li> <li>• Case Manager Code of Ethics (#21)</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>individual's long-term vision through direct communication with the individual, and if needed, through communication with family, guardians, friends and support providers and others who know the individual. Information gathered shall include, but is not limited to the following:</p> <ul style="list-style-type: none"> <li>(a) Strengths;</li> <li>(b) Capabilities;</li> <li>(c) Preferences;</li> <li>(d) Desires;</li> <li>(e) Cultural values;</li> <li>(f) Relationships;</li> <li>(g) Resources;</li> <li>(h) Functional skills in the community;</li> <li>(i) Work interests and experiences;</li> <li>(j) Hobbies;</li> <li>(k) Community membership activities or interests;</li> <li>(l) Spiritual beliefs or interests; and</li> <li>(m) Communication and learning styles or preferences to be used in development of the individual's service plan.</li> </ul> <p>(6) Case Managers shall operate under the presumption that all working age adults with developmental disabilities are capable of working given the appropriate supports. Individuals will be offered employment as a preferred day service over other day service options. It is the responsibility of the Case Manager and all IDT members to ensure that employment decisions are based on informed choices.</p> <p>(a) The Case Manager shall verify that all Jackson Class members who express an interest in work or who have employment-related desired outcome(s) in the ISP have an initial or updated vocational assessment that has been completed within the preceding</p>			
---	--	--	--

<p>twelve (12) months.</p> <p>(b) In cases when employment is not an immediate desired outcome, the ISP shall document the reasons for this decision and develop employment-related goals within the ISP that will be undertaken to explore employment options (e.g., volunteer activities, career exploration, situational assessments, etc.) This discussion related to employment issues shall be documented within the ISP or on the DDS Decision Justification form.</p> <p>(c) In the context of employment, informed choices include the following:</p> <ul style="list-style-type: none"> <li>(i) Information regarding the range of employment options available to the individual</li> <li>(ii) Information regarding self-employment and customized employment options</li> <li>(iii) Job exploration activities including volunteer work and/or trial work opportunities</li> </ul> <p>(7) The Case Manager will ensure discussion on Meaningful Day activities for the individual in the ISP meeting, and reflect such discussion in the ISP “Meaningful Day Definition” section.</p> <p>(8) When a recipient of DD Waiver services has a HAT score of 4, 5, or 6, medical consultation shall be obtained for service planning and delivery, including the ISP and relevant Health Care and Crisis Prevention/Intervention Plans. Medical consultation may be from a Provider Agency Nurse, Primary Care Physician/Practitioner, Regional Office Nurse, Continuum of Care Nurses or Physicians including his or her Regional Medical Consultant and/or RN Nurse Case Manager.</p>			
--	--	--	--

<p>(9) For new allocations, the Case Manager will submit the ISP to NMMUR only after a MAW letter has been received, indicating the individual meets financial and LOC eligibility.</p> <p>(10) The Case Manager, with input from each Provider Agency, shall complete the Individual Specific Training Requirements section of the ISP form listing all training needs specific to the individual.</p> <p>(11) The Case Manager shall complete the initial ISP development within ninety (90) days as required by DDSD.</p>			
--	--	--	--

Tag # 4C09 Secondary FOC	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007  <b>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</b>  <b>G. Secondary Freedom of Choice Process</b></p> <p>(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.</p> <p>(2) The Case Manager will present the Secondary FOC form to the individual or authorized representative for selection of direct service providers.</p> <p>(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.</p>	<p>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 8 of 22 individuals.</p> <p>The following items were not found and/or not agency specific to the individual's current services :</p> <ul style="list-style-type: none"> <li>• <b>Secondary Freedom of Choice</b> <ul style="list-style-type: none"> <li>◦ Supported Living (#3 &amp; 7)</li> <li>◦ Family Living (#12)</li> <li>◦ Adult Habilitation (#12)</li> <li>◦ Community Access (#7, 16 , 21 &amp; 22)</li> <li>◦ Supported Employment (#7, 12 &amp; 16)</li> <li>◦ Behavior Consultation (#21)</li> <li>◦ Speech Therapy (#7, 14 &amp; 21)</li> <li>◦ Physical Therapy (#7 &amp; 21)</li> <li>◦ Occupational Therapy (#13 &amp; 14)</li> <li>◦ Goods &amp; Services (#21)</li> </ul> </li> </ul>	<p><b>Provider:</b>  State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

Tag # 4C10 Apprv. MAD 046 & Budget	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</b></p> <p><b>H. Case Management Approval of the MAD 046 Waiver Review Form and Budget</b></p> <p>(1) Case Management Providers are authorized by DDSD to approve ISPs and budgets (including initial, annual renewals and revisions) for all individuals except as noted in section I of this chapter. This includes approval of support plans and strategies as incorporated in the ISP.</p> <p>(2) The Case Manager shall complete the MAD 046 Waiver Review Form and deliver it to all provider agencies within three (3) working days following the ISP meeting date. Providers will have the opportunity to submit corrections or objections within five (5) working days following receipt of the MAD 046. If no corrections or objections are received from the provider by the end of the fifth (5) working day, the MAD 046 may then be submitted as is to NMMUR. (Provider signatures are no longer required on the MAD 046.) If corrections/objections are received, these will be corrected or resolved with the provider(s) within the timeframe that allow compliance with number (3) below.</p> <p>(3) The Case Manager will submit the MAD 046 Waiver Review Form to NMMUR for review as appropriate, and/or for data entry at least thirty (30) calendar days prior to expiration of the previous ISP.</p> <p>(4) The Case Manager shall respond to NMMUR within specified timelines whenever a MAD 046 is returned for corrections or additional information.</p>	<p>Based on record review, the Agency failed to maintain documentation ensuring the Case Manager completed the MAD 046 Waiver Review Form for 2 of 22 individuals.</p> <p>The following item was not found:</p> <ul style="list-style-type: none"> <li>• MAD 046 for Supported Living (#10 &amp; 21)</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

Tag # 4C12 Monitoring & Evaluation of Services	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</b></p> <p><b>J. Case Manager Monitoring and Evaluation of Service Delivery</b></p> <p>(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.</p> <p>(2) Monitoring and evaluation activities shall include, but not be limited to:</p> <p>(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;</p> <p>(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;</p> <p>(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;</p>	<p>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 1 of 22 individuals.</p> <p><b>Record review of Agency files found no evidence of Case Manager Monthly Case Notes for the following:</b></p> <ul style="list-style-type: none"> <li>• Individual #13 - None found for 12/2011</li> </ul> <p><b>Record review of Agency files found no evidence indicating face-to-face visits were completed as required for the following individuals:</b></p> <ul style="list-style-type: none"> <li>◦ Individual #13 – No Face-to-Face Visit Summary Form was found for 12/2011</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>(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;</p> <p>(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.</p> <p>(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,</p> <p>(g) It is appropriate to conduct face-to-face visits with the individual both during the time the individual is receiving a service</p>			
---	--	--	--



<p>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.</p> <p>(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.</p>			
--	--	--	--

Tag # 4C15.1 - QA Requirements - Bi-Annual Reports & Provider Quarterly Reports	Standard Level Deficiency		
<p><b>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>C. Quality Assurance Requirements:</b> 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:</p> <p>(1) Case Management Provider Agencies are to:</p> <p>(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.</p> <p>(b) Assure that reports and ISPs meet required timelines and include required content.</p> <p>(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.</p> <p>(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.</p>	<p>Based on record review, the Agency failed to ensure reports and ISP meet required timelines and include the required contents for 14 of 22 individuals.</p> <p>The following quarterly/bi-annual reports were not found:</p> <ul style="list-style-type: none"> <li>• <b>Supported Living Quarterly Reports:</b> <ul style="list-style-type: none"> <li>◦ Individual #1 – None found for June 2011 - December 2011.</li> <li>◦ Individual #7 – None found for November 2011 - January 2012.</li> <li>◦ Individual #9 – None found for October 2011 (<i>Agency completes monthly reports not quarterly reports</i>).</li> <li>◦ Individual #14 – None found for July 2011 - October 2011.</li> <li>◦ Individual #18 – None found for August 2011 - November 2011.</li> <li>◦ Individual #20 – None found for September 2011 - November 2011.</li> </ul> </li> <li>• <b>Supported Living Annual Assessment</b> <ul style="list-style-type: none"> <li>◦ Individual #1 – None found for December 2010 – December 2011.</li> <li>◦ Individual #7 – None found for May 2010 - April 2011.</li> </ul> </li> <li>• <b>Family Living Quarterly Reports:</b> <ul style="list-style-type: none"> <li>◦ Individual #12 – None found for January</li> </ul> </li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>(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.</p> <p>(d) Assure at least quarterly that Crisis Prevention/Intervention Plans are in place in 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.</p> <p>(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.</p> <p>(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</p>	<p>2011 - March 2011 &amp; October 2011 - December 2011.</p> <ul style="list-style-type: none"> <li>• <b>Community Inclusion - Adult Habilitation Quarterly Reports:</b> <ul style="list-style-type: none"> <li>◦ Individual #1 – None found for June 2011 - December 2011.</li> <li>◦ Individual #3 – None found for October 2011 (<i>Agency completes monthly reports not quarterly reports</i>).</li> <li>◦ Individual #6 – None found for January 2011 - December 2011.</li> <li>◦ Individual #13 – None found for June 2011 - November 2011.</li> <li>◦ Individual #14 – None found for December 2011 (<i>Agency completes monthly reports not quarterly reports</i>).</li> <li>◦ Individual #15 – None found for October 2011 - December 2011.</li> <li>◦ Individual #21 – None found for January 2011 - December 2011.</li> </ul> </li> <li>• <b>Community Inclusion - Community Access Quarterly Reports:</b> <ul style="list-style-type: none"> <li>◦ Individual #1 – None found for June 2011 - December 2011.</li> <li>◦ Individual #4 – None found for January 2011 - December 2011.</li> <li>◦ Individual #6 – None found for January 2011 - December 2011.</li> <li>◦ Individual #15 – None found for October</li> </ul> </li> </ul>		
--	--	--	--

<p>individual.</p> <p>(g) Perform annual satisfaction surveys with individuals regarding case management services. A copy of the summary is due each December 10<sup>th</sup> to the respective DDSD Regional Office, along with a description of actions taken to address suggestions and problems identified in the survey.</p> <p>(h) Maintain regular communication with all providers delivering services and products to the individual.</p> <p>(i) Establish and implement a written grievance procedure.</p> <p>(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.</p> <p>(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.</p> <p>(2) Case Managers and Case Management Provider Agencies are required to promote</p>	<p>2011 - December 2011.</p> <ul style="list-style-type: none"> <li>◦ Individual #18 – None found for November 2010 - October 2011.</li> </ul> <p>• <b>Community Inclusion - Community Access Annual Assessment:</b></p> <ul style="list-style-type: none"> <li>◦ Individual #1 – None found for December 2010 - December 2011.</li> <li>◦ Individual #6 – None found for July 2010 – July 2011.</li> <li>◦ Individual #7 – None found for May 2010 - April 2011.</li> <li>◦ Individual #14 – None found for April 2010 - March 2011.</li> <li>◦ Individual #18 – None found for November 2010 - November 2011.</li> </ul> <p>• <b>Community Inclusion - Supported Employment Quarterly Reports:</b></p> <ul style="list-style-type: none"> <li>◦ Individual #1 – None found for June 2011 - December 2011.</li> </ul> <p>• <b>Behavior Consultation Quarterly Reports:</b></p> <ul style="list-style-type: none"> <li>◦ Individual #6 – None found for January 2011 - September 2011.</li> </ul> <p>• <b>Speech &amp; Language Pathology Bi-Annual Progress Reports:</b></p> <ul style="list-style-type: none"> <li>◦ Individual #3– None found for December 2010 – November 2011.</li> <li>◦ Individual #7 – None found for September 2010 – August 2011.</li> </ul>		
--	--	--	--

<p>and comply with the Case Management Code of Ethics:</p> <p>(a) Case Managers shall provide the individual/guardian with a copy of the Code of Ethics when Addendum A is signed.</p> <p>(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.</p>	<ul style="list-style-type: none"> <li>• <b>Occupational Bi-Annual Progress Reports:</b> <ul style="list-style-type: none"> <li>◦ Individual #5 – None found for February 2011 – July 2011.</li> <li>◦ Individual #14 – None found for December 2010 – June 2011.</li> </ul> </li> <li>• <b>Physical Bi-Annual Progress Reports:</b> <ul style="list-style-type: none"> <li>◦ Individual #1 – None found for December 2010 – December 2011.</li> <li>◦ Individual #18 – None found for May 2011 – October 2011.</li> </ul> </li> <li>• <b>Quarterly Nursing Reports:</b> <ul style="list-style-type: none"> <li>◦ Individual #7 – None found for July 2011 - December 2011</li> <li>◦ Individual #14 – None found for December 2010 - January 2011.</li> <li>◦ Individual #20 – None found for September 2011 - November 2011.</li> </ul> </li> </ul>		
--	---	--	--

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<b>CMS Assurance – Level of Care – Initial and annual Level of Care (LOC) evaluations are completed within timeframes specified by the State.</b>			
<b>Tag # 4C04 Assessment Activities</b>	<b>Standard Level Deficiency</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</b></p> <p><b>B. Case Management Assessment Activities:</b> Assessment activities shall include but are not limited to the following requirements:</p> <p>(1) Complete and compile the elements of the Long Term Care Assessment Abstract (LTCAA) packet to include:</p> <p>(a) LTCAA form (MAD 378);</p> <p>(b) Comprehensive Individual Assessment (CIA);</p> <p>(c) Current physical exam and medical/clinical history;</p> <p>(d) Norm-referenced adaptive behavioral assessment; and</p> <p>(e) A copy of the Allocation Letter (initial submission only).</p> <p>(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</p>	<p>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 22 individuals.</p> <p>The following items were not found and/or incomplete:</p> <ul style="list-style-type: none"> <li>• Annual Physical (#8)</li> <li>• Client Individual Assessment (CIA) (#8)</li> <li>• Adaptive Behavior Scale (ABS) (#8)</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>in the DD Waiver program. (3) Provide a copy of the MAW letter to service providers listed on the ISP budget (MAD 046).</p>			
--	--	--	--

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p><b>CMS Assurance – Qualified Providers</b> – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.</p>			
<p><b>Tag # 1A22 &amp; 4C02 Case Management Competencies &amp; Knowledge of Services</b></p>	<p><b>Standard Level Deficiency</b></p>		
<p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title:</b> Training Requirements for Case Management Agency Staff Policy - <b>Eff. March 1, 2007</b></p> <p><b>II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified case managers.</p> <p>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.</p> <p>C. Case management staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p> <p>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...</p> <p>E. Substitutes shall comply with the training requirements of the staff for whom they are substituting.</p> <p>F. To complete a core curriculum-training</p>	<p>Based on interview, the Agency failed to ensure training competencies, as well as awareness of how to complete tasks related to the Scope of Case Management Services for 1 of 8 Case Managers.</p> <p><b>When the Case Manager was asked, how do you ensure the individuals most current annual ISP is in place prior to the expiration of their old one, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• #28 reported not knowing how to answer the question and stated, “That they have new goals.” Surveyor rephrased the question several times, nevertheless, the Case Manager was unable to answer what is done to ensure the most current ISP is in place prior to the expiration of the old one. (Individual #5, 8, 11 &amp; 18).</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	



<p>course, trainees shall achieve 100% competency rating during the competency verification process.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 4 II. SCOPE OF CASE MANAGEMENT SERVICES:</b> Case Management shall include, but is not limited to, the following services:</p> <ul style="list-style-type: none"> <li><b>A.</b> Facilitate eligibility determination for the DD Waiver and other types of services;</li> <li><b>B.</b> Organize and facilitate the service planning process in accordance with the regulation Service Plans for Individuals with Developmental Disabilities Living in the Community [7.26.5 NMAC];</li> <li><b>C.</b> Assist the IDT members to explore alternatives to DD Waiver services and assist in the development of complementary or supplemental supports, including other publicly funded programs, community resources available to all citizens and natural supports within the individuals' community;</li> <li><b>D.</b> Coordinate and monitor service delivery, including assuring services are delivered as described in the ISP and are provided in a safe and healthy environment;</li> <li><b>E.</b> Through a formal, ongoing monitoring process, evaluate and document quality, effectiveness and appropriateness of services and supports;</li> <li><b>F.</b> If concerns are identified and unresolved by the Case Manager or service Provider</li> </ul>			
---	--	--	--

<p>Agency in a timely manner, the Case Manager will report the concern in writing to the respective DDSD Regional Office and/or DHI as appropriate;</p> <p><b>G.</b> Arrange for information about supported employment to be shared with the individual, in a manner consistent with the DDSD Employment First Principle, to insure the individual can make an informed choice;</p> <p><b>H.</b> Develop and monitor utilization of ARA budgets;</p> <p><b>I.</b> Timely submission of revisions to the ARA budget, if needed;</p> <p><b>J.</b> Coordinate and/or advocate for the revision of services when desired outcomes are not achieved;</p> <p><b>K.</b> Inform the individual of his or her rights and responsibilities at least annually, and promote informed decision-making;</p> <p><b>L.</b> Promote self-advocacy;</p> <p><b>M.</b> Advocate on behalf of the individual, as needed;</p> <p><b>N.</b> Monitor the health and safety of the individual;</p> <p><b>O.</b> Maintain a current and complete primary record for individual's DD Waiver services as specified in DDSD policy;</p> <p><b>P.</b> Complete and approve Level of Care (LOC) packets as outlined in this standard;</p>			
---	--	--	--

<p><b>Q.</b> Approve the ISPs and the Waiver Review Form (MAD 046) as outlined in this standard;</p> <p><b>R.</b> Assure that the IDT members develop targeted, realistic desired outcomes and action plans with measurable action steps and that the ISP is cost effective; and</p> <p><b>S.</b> Meet with the individual, and family/guardian if applicable, and describe the optional Personal Plan Facilitation service available to supplement the individual service plan process. If requested, assist the individual in obtaining this service through the Freedom of Choice process.</p> <p><b>T.</b> Assure individuals obtain all services through the Freedom of Choice process.</p>			
--	--	--	--

Tag # 1A26 Consolidated On-line Registry / Employee Abuse Registry	Standard Level Deficiency		
<p><b>NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:</b> Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. <b>Provider requirement to inquire of registry.</b> A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. <b>Prohibited employment.</b> A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. <b>Documentation of inquiry to registry.</b> 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</p>	<p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 3 of 9 Agency Personnel.</p> <p><b>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</b></p> <ul style="list-style-type: none"> <li>• #29 – Date of hire 11/14/2011. Completed on 1/10/2012.</li> <li>• #30 – Date of hire 8/29/2011. Completed on 1/10/2012.</li> <li>• #31 – Date of hire 4/27/1989. Completed on 5/4/2010.</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. <b>Documentation for other staff.</b> 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.</p> <p>F. <b>Consequences of noncompliance.</b> The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007  <b>Chapter 1.IV. General Provider Requirements. D. Criminal History Screening:</b> 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</p>			
--	--	--	--

Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency		
<p><b>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p><b>D. Training Documentation:</b> All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p> <p><b>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</b></p> <p><b>II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from</p>	<p>Based on interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 1 of 9 Agency Personnel.</p> <p><b>When Case Managers were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect &amp; Misappropriation of Consumers' Property, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• #28 stated, "Would report to IMB-DOH, agency and guardian." Case Manager was unable to identify APS as the second State Agency.</li> </ul> <p><b>When Case Managers were asked to give examples of Abuse, Neglect &amp; Misappropriation of Consumers' Property, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• #28 stated, "Abuse is hitting, have bruising. Neglect is falling or not feeding." When asked to give an example of exploitation, the Case Manager stated "I don't know."</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

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

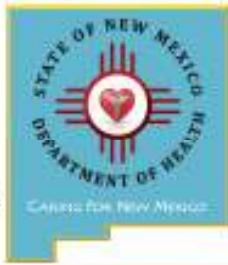


Tag # 4C17 Case Manager Qualifications - Required Training	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>E. Case Manager Qualifications:</b> Case Managers, whether subcontracting or employed by a Provider Agency, shall meet these requirements:</p> <p>(1) Case Managers shall possess these qualifications: ...</p> <p>(2) Within specified timelines, Case Managers shall meet the requirements for training specified in the DDS policy governing the training requirements for Case Managers serving individuals with developmental disabilities. All Case Management Provider Agencies are required to report required personnel training status to the DDS Statewide Training Database as follows:</p> <p>(a) Initial comprehensive personnel status report (name, date of hire, identification number category) on all required personnel to be submitted to DDS Statewide Training Database within the first ninety (90) calendar days of providing services; and</p> <p>(b) Quarterly personnel update reports sent to DDS Statewide Training Database to reflect new hires, terminations, or agency position changes, and name changes.</p> <p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDS) Policy - Policy Title: Training</b></p>	<p>Based on record review, the Agency failed to ensure that Training requirements were met for 3 of 8 Case Managers.</p> <p>Review of Case Manager training records found no evidence of the following required DOH/DDS trainings being completed:</p> <ul style="list-style-type: none"> <li>• Pre-Service Manual (#23, 27 &amp; 29)</li> <li>• Promoting Effective Teamwork (#27)</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>Requirements for Case Management Agency Staff Policy - <b>Eff. March 1, 2007</b></p> <p><b>II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified case managers.</p> <p>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.</p> <p>C. Case management staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p> <p>D. In addition to the applicable requirements described in policy statements B – C (above), case managers and case management supervisors shall complete DDS-approved core curriculum training...</p> <p>E. Substitutes shall comply with the training requirements of the staff for whom they are substituting.</p> <p>F. To complete a core curriculum-training course, trainees shall achieve 100% competency rating during the competency verification process.</p>			
--	--	--	--

Tag # 1A29 Complaints / Grievances - Acknowledgement	Standard Level Deficiency		
<p><b>NMAC 7.26.3.6</b>  A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC].</p> <p><b>NMAC 7.26.3.13 Client Complaint Procedure Available.</b> A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p><b>NMAC 7.26.4.13 Complaint Process:</b>  <b>A. (2).</b> The service provider's complaint or grievance procedure shall provide, at a minimum, that: <b>(a)</b> the client is notified of the service provider's complaint or grievance procedure</p>	<p>Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 22 individuals.</p> <ul style="list-style-type: none"> <li>Grievance/Complaint Procedure Acknowledgement (#21)</li> </ul>	<p><b>Provider:</b>  State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p><b>CMS Assurance – Financial Accountability</b> – <i>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</i></p>			
<p><b>TAG #1A12 All Services Reimbursement (No Deficiencies)</b></p>			
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 <b>Chapter 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>B. Billable Units:</b> The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ul style="list-style-type: none"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ul> <p>Billing for Case Management services was reviewed for 22 of 22 individuals. <i>Progress notes and billing records supported billing activities for the months of October, November and December 2011.</i></p>			



SUSANA MARTINEZ, GOVERNOR

CATHERINE D. TORRES, M.D., CABINET SECRETARY

Date: June 4, 2012

To: Ms. Diane Metoyer, Executive Director

Provider: Excel Case Management, Inc.  
Address: 626 East Main Street  
State/Zip: Farmington, New Mexico 87401

CC: Mr. Dave Dunaway, Board Chair  
Address: 804 West 24<sup>th</sup> Street  
State/Zip: Farmington, New Mexico 87401

Region: Northwest  
Survey Date: February 6 – 8, 2012  
Program Surveyed: Developmental Disabilities Waiver  
Services Surveyed: Case Management  
Survey Type: Routine

Dear Ms. Metoyer:

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

**The Plan of Correction process is now complete.**

**Furthermore, your agency is now determined to be in Compliance with all Conditions of Participation.**

Consistent use these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Scott Good  
QMB Deputy Chief  
Quality Management Bureau/DHI

