



SUSANA MARTINEZ, GOVERNOR

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

Date: June 25, 2012

To: Angelica Chavez, Case Manager Supervisor
Provider: J & J Homecare, Inc.
Address: 105 W. 3rd Street
State/Zip: Roswell, NM 88201

E-mail Address: achavez@jjhc.org

CC: Joyce Munoz, Owner
E-Mail Address: jmunoz@jjhc.org

Region: Southeast
Survey Date: March 19 – 22, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Case Management
Survey Type: Routine
Team Leader: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Marti Madrid, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Chavez;

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 – J & J Homecare, Inc. – Southeast Region – March 19 – 22, 2012

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,

Deb Russell

Deb Russell, BS
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	March 19, 2012
Present:	<u>J & J Homecare, Inc.</u> Mary Lou Thomas, Chief Operations Officer <u>DOH/DHI/QMB</u> Deb Russell, BS, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor
Exit Conference Date:	March 22, 2012
Present:	<u>J & J Homecare, Inc.</u> Joyce Munoz, Chief Executive Officer, Owner Lisa Garcia, Case Manager Angela Chavez, Case Manager Supervisor <u>DOH/DHI/QMB</u> Deb Russell, BS, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor <u>DDSD - Southeast Regional Office</u> Debra Ortiz, Case Management Coordinator
Administrative Locations Visited (NM)	Number: 2 (1301 Grand, Artesia, NM & 3 rd Street, Roswell, NM)
Total Sample Size	Number: 24 3 - <i>Jackson</i> Class Members 21 - <i>Non-Jackson</i> Class Members
Persons Served Records Reviewed	Number: 24
Case Managers Interviewed	Number: 5
Case Mgt Personnel Records Reviewed	Number: 12
Administrative Files Reviewed	<ul style="list-style-type: none">• 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 – J & J Homecare, Inc. – Southeast Region – March 19 – 22, 2012

Q.12.03.DDW.D4045.4.001.RTN.01.167

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. 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 Scott Good, POC Coordinator in any of the following ways:
 - a. Electronically at scott.good@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 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: J & J Homecare, Inc. - Southeast Region
Program: Developmental Disabilities Waiver
Service: Case Management
Monitoring Type: Routine Survey
Date of Survey: March 19 – 22, 2012

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>CMS Assurance – Plan of Care - ISP Development & Monitoring – Service plans address all participates’ 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>Tag # 1A08 Agency Case File</p>	<p>Standard Level Deficiency</p>		
<p>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:</p>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 14 of 24 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Did not contain Health Plan Information (#8 & 16) • ISP Assessment Checklist (#12 & 14) • ISP Signature Page <ul style="list-style-type: none"> ◦ None Found (#8 & 11) • ISP Teaching & Support Strategies <ul style="list-style-type: none"> ◦ <i>Individual #1 - TASS not found for:</i> ◦ Outcome Statement #1 – Learn how to type <ul style="list-style-type: none"> ➢ Learn how to type using the programs purchased 	<p>Provider: 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>(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;</p> <p>(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);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(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;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge</p>	<ul style="list-style-type: none"> ◦ <i>Individual #8 - TASS not found for:</i> ◦ Outcome Statement #1 – Learn how to prepare Mexican dishes <ul style="list-style-type: none"> ➢ Find recipe he wants to prepare ➢ Prepare list of ingredients he will need ➢ Prepare his recipe ◦ Outcome Statement #2 – Would like to look his very best for work <ul style="list-style-type: none"> ➢ Shave everyday ➢ Brush his teeth everyday ➢ Have his hair trimmed monthly ◦ Outcome Statement #3 – Go to library to look up recipes <ul style="list-style-type: none"> ➢ Go to library ➢ Use the internet to look-up recipes ➢ Create a cookbook of recipes he collects <ul style="list-style-type: none"> • Positive Behavioral Plan (#23) • Speech Therapy Plan (#2, 16 & 23) • Occupational Therapy Plan (#14) • Physical Therapy Plan (#13) • Health Care Plans <ul style="list-style-type: none"> • <i>Aspiration</i> <ul style="list-style-type: none"> ◦ Individual #24 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • <i>Body Mass Index</i> <ul style="list-style-type: none"> ◦ Individual #7 - According to the electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of plan found. 		
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<p>from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>	<ul style="list-style-type: none"> • <i>Bowel & Bladder</i> <ul style="list-style-type: none"> ◦ Individual #7 - According to the electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of plan found. • <i>Skin Impairment</i> <ul style="list-style-type: none"> ◦ Individual #24 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • <i>Tubular Sclerosis</i> <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • Crisis Plans/Medical Emergency Response Plans <ul style="list-style-type: none"> • Aspiration <ul style="list-style-type: none"> ◦ Individual #24 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • Seizures <ul style="list-style-type: none"> ◦ Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • Skin Impairment <ul style="list-style-type: none"> ◦ Individual #24 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • Tubular Sclerosis <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. 		
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	<p>Other Individual Specific Evaluations & Examinations:</p> <ul style="list-style-type: none"> • Dental Exam <ul style="list-style-type: none"> ◦ Individual #1 - As indicated by the DDS file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found. ◦ Individual #11 - As indicated by the DDS file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found. • Auditory Exam <ul style="list-style-type: none"> ◦ Individual #1 - As indicated by the ISP Assessment Tracking Sheet, the exam was to be scheduled. No documented evidence of the exam being completed was found. • Vision Exam <ul style="list-style-type: none"> ◦ Individual #1 - As indicated by the DDS file matrix Vision Exams are to be conducted every other year. No documented evidence of exam was found. ◦ Individual #4 - As indicated by the DDS file matrix Vision Exams are to be conducted every other year. No documented evidence of exam was found. ◦ Individual #10 - As indicated by the documentation reviewed, exam was completed on 10/11/2010. Follow-up was to be completed in 12 months. No documented evidence of the follow-up being completed was found. ◦ Individual #11 - As indicated by the DDS file matrix Vision Exams are to be 		
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	<p>conducted every other year. No documented evidence of exam was found.</p> <ul style="list-style-type: none"> • Prostate Specific Antigen (PSA) <ul style="list-style-type: none"> ◦ Individual #22 - As indicated by the documentation reviewed, exam was scheduled for 2/23/2012. No documented evidence was found to verify visit was completed. • Colonoscopy <ul style="list-style-type: none"> ◦ Individual #8 - As indicated by the History & Physical 2/14/2012, exam was recommended. No documented evidence was found to verify visit was completed. • Blood Levels <ul style="list-style-type: none"> ◦ Individual #1 - As indicated by the documentation reviewed, lab work (CBC, CMP, Lipid, TSH, UA) was ordered on 6/23/2011. No documented evidence found to verify it was completed. ◦ Individual #10 - As indicated by the documentation reviewed, lab work (CMP, Mag, Phos) was ordered on 4/8/2011. No documented evidence found to verify it was completed. • Follow-up with Urologist <ul style="list-style-type: none"> ◦ Individual #1 - As indicated by the 1/27/2012 doctor's visit, the exam was recommended. No documented evidence of the exam being completed was found. • Positive Behavior Support Assessment (#4 & 23) 		
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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>CHAPTER 4 II. SCOPE OF CASE MANAGEMENT SERVICES: 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 24 individuals.</p> <p>No evidence was found of the following:</p> <ul style="list-style-type: none"> • Primary Freedom of Choice (#8) 	<p>Provider: 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 # 4C07 Individual Service Planning	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</p> <p>E. Individualized Service Planning and Approval:</p> <p>(1) Individualized service planning is developed through a person-centered planning process in accordance with the rule governing ISP development (7.26.5 NMAC). A person-centered planning process shall be used to develop an ISP that includes:</p> <p>(a) Realistic and measurable desired outcomes for the individual as identified in the ISP which includes the individual's long-term vision, summary of strengths, preferences and needs, desired outcomes and an action plan and is:</p> <p>(i) An ongoing process, based on the individual's long-term vision, and not a one-time-a-year event; and</p> <p>(ii) Completed and implemented in response to what the IDT members learn from and about the person and involves those who can support the individual in achieving his or her desired outcomes (including family, guardians, friends, providers, etc.).</p> <p>(2) The Case Manager will ensure the ongoing assessment of the individual's strengths, needs and preferences and use this information to inform the IDT members and guide the development of the plan.</p>	<p>Based on record review the Agency failed to ensure Case Managers developed realistic and measurable desired outcomes for the individual as identified in the ISP which includes the individual's long-term vision, summary of strengths, preferences and needs, desired outcomes and an action plan for 8 of 24 Individuals.</p> <p>The following was found with regards to ISP Outcomes:</p> <ul style="list-style-type: none"> • Individual #1: <ul style="list-style-type: none"> ◦ 'Learn how to type' Outcome does not indicate how and/or when it would be completed. ◦ 'Look at movies' Outcome does not indicate how and/or when it would be completed. ◦ 'Go out in community' Outcome does not indicate how and/or when it would be completed. • Individual #4: <ul style="list-style-type: none"> ◦ 'Work on cooking skills' Outcome does not indicate how and/or when it would be completed. ◦ 'Work at Edison Elementary' Outcome was does not indicate how and/or when it would be completed. ◦ 'Go on outing 1 time per month with cousin' Outcome does not indicate how and/or when it would be completed. • Individual #8: 	<p>Provider: 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>7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS: Each ISP shall contain...</p> <p>C. Outcomes:</p> <p>(1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP.</p> <p>(2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.</p>	<ul style="list-style-type: none"> ◦ 'Learn how to prepare Mexican dishes' Outcome does not indicate how and/or when it would be completed. ◦ 'Would like to look his very best at work' Outcome does not indicate how and/or when it would be completed. ◦ 'Go to the library at least 2 times per month for 1 year' is desired outcome in ISP. 'Will go to the library at least once a week to look up recipes' is outcome noted on Action Plan. • Individual #9: <ul style="list-style-type: none"> ◦ 'Set the table' Outcome does not indicate how and/or when it would be completed. • Individual #10 <ul style="list-style-type: none"> ◦ 'Learn appropriate greetings' Outcome does not indicate how and/or when it would be completed. ◦ 'Purchase appropriate clothing for season' Outcome does not indicate how and/or when it would be completed. • Individual #13: <ul style="list-style-type: none"> ◦ 'Improve self-esteem' Outcome does not indicate how and/or when it would be completed. ◦ 'Go to library' Outcome does not indicate how and/or when it would be completed. ◦ 'Wants a pretty smile' Outcome does not indicate how and/or when it would be completed. • Individual #16: 		
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	<ul style="list-style-type: none"> ◦ 'Learn how to match pictures with words' Outcome does not indicate how and/or when it would be completed. ◦ 'Label pictures of activities he has participated in' Outcome does not indicate how and/or when it would be completed. • Individual #24: <ul style="list-style-type: none"> ◦ 'Learn to make his bed' Outcome does not indicate how and/or when it would be completed. ◦ 'Relax by enjoying beverage of his choice' Outcome does not indicate how and/or when it would be completed. ◦ 'Go to art class for different projects' Outcome does not indicate how and/or when it would be completed. 		
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Tag # 4C09 Secondary FOC	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS G. Secondary Freedom of Choice Process</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 Freedoms of Choice documentation and ensure individuals obtained all services through the Freedom of Choice Process for 4 of 24 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"> • Secondary Freedom of Choice <ul style="list-style-type: none"> ◦ Independent Living (#8 & 12) ◦ Adult Habilitation (#12 & 16) ◦ Supported Employment (#8 & 12) ◦ Occupational Therapy/COTA (#14) 	<p>Provider: 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>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</p> <p>H. Case Management Approval of the MAD 046 Waiver Review Form and Budget</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</p>	<p>Based on record review the Agency failed to maintain documentation ensuring the Case Manager completed the MAD046 Waiver Review Form for 1 of 24 individuals.</p> <p>The following item was not found:</p> <ul style="list-style-type: none"> • MAD 046 (#21) 	<p>Provider: 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>	

corrections or additional information.			
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Tag # 4C12 Monitoring & Evaluation of Services	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</p> <p>J. Case Manager Monitoring and Evaluation of Service Delivery</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 24 individuals.</p> <p>Record review of Agency files found no evidence indicating face-to-face visits were completed as required for the following individuals:</p> <ul style="list-style-type: none"> ◦ Individual #2 – No Face-to-Face Visit Summary Forms found for 4/2011 & 5/2011. 	<p>Provider: 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</p>			
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<p>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.</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>			
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Tag # 4C15.1 - QA Requirements - Bi-Annual Reports & Provider Quarterly Reports	Standard Level Deficiency		
<p>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</p> <p>C. Quality Assurance Requirements: Case Management Provider Agencies will use an Internal Quality Assurance and Improvement Plan that must be submitted to and reviewed by the Statewide Case Management Coordinator, that shall include but is not limited to the following:</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 that reports and ISP's meet required timelines and include the required contents for 8 of 24 individuals.</p> <p>The following quarterly/bi-annual reports were not found:</p> <ul style="list-style-type: none"> • Supported Living Annual Assessment <ul style="list-style-type: none"> ◦ Individual #10 – None found for 8/2010 – 7/2011. ◦ Individual #18 – None found for 7/2010 – 6/2011. • Family Living Annual Assessment <ul style="list-style-type: none"> ◦ Individual #5 – None found for 2/2011 – 1/2012. • Independent Living Annual Assessment <ul style="list-style-type: none"> ◦ Individual #8 – None found for 3/2011 – 2/2012. • Community Inclusion - Community Access Annual Assessment: <ul style="list-style-type: none"> ◦ Individual #23 – None found for 4/2010 – 3/2011. • Community Inclusion - Supported Employment Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #8 – None found for 1/2011 – 12/2011. ◦ Individual #12 – None found for 7/2011 – 9/2011. 	<p>Provider: 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>	<ul style="list-style-type: none"> • Behavior Consultation Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #23 – None found for 3/2011 – 2/2012. • Speech & Language Pathology Bi-Annual Progress Reports: <ul style="list-style-type: none"> ◦ Individual #1 – None found for 7/2011 – 1/2012. ◦ Individual #16 – None found for 11/2010 – 5/2011. ◦ Individual #23 – None found for 4/2011 – 10/2011. • Occupational Bi-Annual Progress Reports: <ul style="list-style-type: none"> ◦ Individual #23 – None found for 4/2011 – 10/2011. 		
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<p>individual.</p> <p>(g) Perform annual satisfaction surveys with individuals regarding case management services. A copy of the summary is due each December 10th to the respective DDSD Regional Office, along with a description of actions taken to address suggestions and problems identified in the survey.</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</p>			
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<p>Provider Agencies are required to promote and comply with the Case Management Code of Ethics:</p> <ul style="list-style-type: none">(a) Case Managers shall provide the individual/guardian with a copy of the Code of Ethics when Addendum A is signed.(b) Complaints against a Case Manager for violation of the Code of Ethics brought to the attention of DDS will be sent to the Case Manager's supervisor who is required to respond within 10 working days to DDS with detailed actions taken. DDS reserves the right to forward such complaints to the IRC.			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>CMS Assurance – Qualified Providers – 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>Tag # 1A25 Caregiver Criminal History Screening</p>	<p>Standard Level Deficiency</p>		
<p>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</p> <p>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</p> <p>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: A. homicide; B. trafficking, or trafficking in controlled</p>	<p>Based on record review, the Agency failed to maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 1 of 12 Agency Personnel.</p> <p>The following Agency Personnel Files contained Caregiver Criminal History Screenings, which were not specific to the Agency:</p> <ul style="list-style-type: none"> • #45 – Date of hire 7/11/2011. 	<p>Provider: 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>substances;</p> <p>C. kidnapping, false imprisonment, aggravated assault or aggravated battery;</p> <p>D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;</p> <p>E. crimes involving adult abuse, neglect or financial exploitation;</p> <p>F. crimes involving child abuse or neglect;</p> <p>G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</p> <p>H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p>			
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Tag # 1A26 Consolidated On-line Registry / Employee Abuse Registry	Standard Level Deficiency		
<p>NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such</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 5 of 12 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #41 – Date of hire 12/15/2011. Completed on 12/28/2011. • #46 – Date of hire 11/8/2011. Completed on 1/10/2012. • #48 – Date of hire 6/9/2009. Completed on 3/20/2010. • #49 – Date of hire 5/24/2010. Completed on 9/4/2010. • #51 – Date of hire 10/8/2008. Completed on 10/14/2008. 	<p>Provider: 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. 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.</p> <p>F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.</p> <p>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</p>			
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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 # 4C20 Supervision Req.	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</p> <p>H. Case Management Provider Agency Supervision Requirements</p> <p>(1) Provider Agencies shall implement written procedures for training, supervision and corrective action for Case Management staff and/or subcontractors. Documentation of above needs to be maintained in personnel files.</p> <p>(2) Individuals providing supervision/oversight must have at least two (2) years as experienced Case Managers for individuals with developmental disabilities and must meet all qualifications for Case Managers under Section IV, E, (1). Case management supervisors who also carry a caseload may not perform quality assurance reviews on their own work.</p> <p>(3) Contract performance management procedures equivalent to employee supervision procedures shall be carried out for Case Management sub-contractors.</p> <p>(4) Provider Agencies shall monitor and oversee the eligibility process for new allocations and for re-determinations.</p> <p>(5) On a quarterly basis, Provider Agencies are required to mentor and monitor service planning and ISP development by Case Managers, including a quality assurance</p>	<p>Based on record review, the agency failed to implement written procedures for training, supervision and corrective action for Case Management staff and/or Subcontractors.</p> <p>During the on-site week of March 19, 2012 a copy of the agency's policy and procedure regarding case management training, supervision and correction action for Case Management staff and/or subcontractors was requested. The information provided by the Agency of the Agency's policy and procedures did not contain:</p> <ul style="list-style-type: none"> • Corrective action for Case Management staff and/or subcontractors. 	<p>Provider: 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>review of a sample of ISPs written by each Case Manager. For Jackson Class members, all ISPs are required to be reviewed; for non-Jackson Class members, a ten percent (10%) sample is required. Copies of all critiqued ISPs, both Jackson and non-Jackson samples, shall be submitted to the respective DDS Regional Office.</p> <p>(6) Provider Agencies are required to evaluate the quality of monitoring conducted by Case Managers with regard to ISP implementation and health and safety for individuals served, including timely medical intervention to follow-up on recommendations by medical and/or clinical practitioners.</p> <p>(7) Provider Agencies shall oversee Quality Assurance and Improvement Requirements for Case Managers.</p> <p>(8) Provider Agencies shall assure Case Manager compliance with training requirements.</p> <p>(9) Provider Agencies are required to assure all records include current provider quarterly reports and that each record is complete in adherence with DDS policies, procedures and standards.</p> <p>(10) Provider Agencies must assure adherence to timelines set forth by DDS.</p>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>CMS Assurance – Financial Accountability – <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>TAG #1A12 All Services Reimbursement (No Deficiencies)</p>			
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 Chapter 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ul style="list-style-type: none"> (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. <p>Billing for Case Management services was reviewed for 24 of 24 individuals. <i>Progress notes and billing records supported billing activities for the months of November & December 2011 & January 2012.</i></p>			



SUSANA MARTINEZ, GOVERNOR

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

Date: September 21, 2012

To: Angelica Chavez, Case Manager Supervisor
Provider: J & J Homecare, Inc.
Address: 105 W. 3rd Street
State/Zip: Roswell, NM 88201

E-mail Address: angelac@jjhc.org

CC: Joyce Munoz, Owner
E-Mail Address: joycem@jjhc.org

Region: Southeast
Survey Date: March 19 – 22, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Case Management
Survey Type: Routine

Dear Ms. Chavez;

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.

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

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,

Crystal Lopez-Beck
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.13.01.DDW.D4045.4.001.RTN.09.265

