



Date: July 13, 2012

To: Sherrie Binkley, Executive Director
 Provider: Peak Developmental Services, Inc.
 Address: 3500 Comanche Rd, NE Suite C
 State/Zip: Albuquerque, New Mexico, 87107

E-mail Address: peakcm@gmail.com

Region: Metro & Northeast
 Survey Date: June 4 – 7, 2012
 Program Surveyed: Developmental Disabilities Waiver
 Service Surveyed: Case Management
 Survey Type: Routine
 Team Leader: Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
 Team Members: Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Stephanie Berenger, MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Tony Fragua, BFA, Healthcare Surveyor, Division of Health/Quality Management Bureau; Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Corrine Strain, RN, BSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Cynthia Nielsen, MSN, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mrs. Binkley,

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 – Peak Developmental Services, Inc. – Metro & Northwest– June 4 – 7, 2012

Survey Report #: Q.12.4.DDW.D2793.1&5.001.RTN.1.195

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 505-699-9356 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Nadine Romero, LBSW

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

Survey Process Employed:

Entrance Conference Date: June 4, 2012

Present: **Peak Developmental Services, Inc.**
Sherrie Binkley, Executive Director
Sandra Damon, Case Manager
Rena Wynne, Case Manager

DOH/DHI/QMB

Nadine Romero, LBSW, Team Lead/Healthcare Surveyor
Jennifer Bruns, BSW Healthcare Surveyor
Erica Nilsen, BA Healthcare Surveyor
Cynthia Nielsen, MSN, RN, Healthcare Surveyor
Corrina Strain, BSN, RN, Healthcare Surveyor
Tony Fragua, BFA, Healthcare Surveyor
Stephanie Martinez de Berenger, MBA

Exit Conference Date: June 7, 2012

Present: **Peak Developmental Services, Inc.**
Sherrie Binkley, Executive Director
Sandra Damon, Case Manager
Rena Wynne, Case Manager
Socorro Reyes, Case Manager
Angie Meyer, Case Manager
Julia McSweeney, Case Manager
Susan McElewee, Case Manager
Rachael Reddington, Case Manager
Anna Palacio, Case Manager
Theresa Weaver, Case Manager
Mark Williams, Case Manager
Patricia Duran, Case Manager
Jamie Tropin, Case Manager
Daniel Romero, Case Manager
April Gonzales, Case Manager
Kelly Thomas, Case Manager

DOH/DHI/QMB

Nadine Romero, LBSW, Team Lead/Healthcare Surveyor
Jennifer Bruns, BSW Healthcare Surveyor
Corrina Strain, BSN, RN, Healthcare Surveyor

Administrative Locations Visited	Number:	1
Total Sample Size	Number:	42 8 - <i>Jackson</i> Class Members 34 - <i>Non-Jackson</i> Class Members
Persons Served Records Reviewed	Number:	42
Case Managers Interviewed	Number:	16

QMB Report of Findings – Peak Developmental Services, Inc. – Metro & Northwest– June 4 – 7, 2012

Survey Report #: Q.12.4.DDW.D2793.1&5.001.RTN.1.195

Case Mgt Personnel Records Reviewed

Number: 16

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

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 505-699-9356 or email at Crystal.Lopez-Beck@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 QMB POC Coordinator, Crystal Lopez-Beck at 505-699-9356 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:

QMB Report of Findings – Peak Developmental Services, Inc. – Metro & Northwest– June 4 – 7, 2012

- a. Electronically at Crystal.Lopez-Beck@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 QMB.
 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 Deputy Chief 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: Peak Developmental Services, Inc. - Metro & Northwest Region
Program: Developmental Disabilities Waiver
Service: Case Management
Monitoring Type: Routine Survey
Date of Survey: June 4 – 7, 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</p>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 21 of 42 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"> • Annual ISP <ul style="list-style-type: none"> ◦ Not Current (#25) • ISP Signature Page <ul style="list-style-type: none"> ◦ None Current (#25) • Addendum A (#25) • Individual Specific Training Section (ISP) (#25) • ISP Teaching & Support Strategies 	<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>representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <ol style="list-style-type: none"> (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: <ol style="list-style-type: none"> (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; 	<ul style="list-style-type: none"> ◦ <i>Individual #9 - TASS not found for:</i> ◦ Outcome Statement # 1 – “Paying bills.” <ul style="list-style-type: none"> ➢ “Will sit down and pay bills.” ➢ “Will go to bank and get statement.” ◦ Outcome Statement # 2 – “Increase productivity.” <ul style="list-style-type: none"> ➢ “Increase by 5%.” ◦ Outcome Statement #3 – “Will invite peer to sporting event.” <ul style="list-style-type: none"> ➢ “Choose event.” ➢ “Invite peer.” ◦ <i>Individual #13 - TASS not found for:</i> ◦ Outcome Statement #1 – “Manage activities in the home.” <ul style="list-style-type: none"> ➢ “Will make choices about her home is decorated.” ◦ Outcome Statement #3 – “Spend time getting to know roommates.” <ul style="list-style-type: none"> ➢ “Get to know her roommates.” ◦ <i>Individual #14 - TASS not found for:</i> ◦ Outcome Statement # 2 – “Participate in a sorting activity.” <ul style="list-style-type: none"> ➢ “Will participate in a sorting activity one time a week increasing my time on task to 30 seconds within the next 3 months.” ➢ “Participate in a sorting activity one time a week, increasing my time on task to 1 minute within the next 6 months.” ◦ <i>Individual #16 - TASS not found for:</i> ◦ Outcome Statement #2 – “Choose an activity.” <ul style="list-style-type: none"> ➢ “Will choose an activity.” 		
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<p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>	<ul style="list-style-type: none"> ◦ <i>Individual #17 - TASS not found for:</i> ◦ Outcome Statement #1 – “Will safely have alone time 2 times a week in his home.” <ul style="list-style-type: none"> ➤ “Will explore his neighborhood to find places of interest.” ◦ Outcome Statement #2 – “Will increase his hours at work for the next ISP year.” <ul style="list-style-type: none"> ➤ “Will work his entire shift.” ◦ Outcome Statement #3 – “Will maintain good healthy relationships by visiting 2 times a month with his mother and family.” <ul style="list-style-type: none"> ➤ “Will visit his mom 2 times a month.” ◦ Outcome Statement #4 – “Will learn to get to his favorite place in the community by taking the bus.” <ul style="list-style-type: none"> ➤ “Will learn to take the public bus with ABW staff.” ◦ <i>Individual #36 - TASS not found for:</i> ◦ Outcome Statement #3 – “Will plan 5 out of town activities.” <ul style="list-style-type: none"> ➤ “Will choose and plan activities.” ➤ “Will attend activity as planned.” <ul style="list-style-type: none"> • Positive Behavioral Plan (#17 & 28) • Positive Behavioral Crisis Plan (#7, 9 & 17) • Speech Therapy Plan (#1 & 8) • Occupational Therapy Plan (#32) • Physical Therapy Plan (#9, 13 & 35) 		
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	<ul style="list-style-type: none"> • Electronic Health Assessment Tool (eChat) (#9, 15 & 42) • Health Care Plans <ul style="list-style-type: none"> • Aspiration <ul style="list-style-type: none"> ◦ Individual #28 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • BMI <ul style="list-style-type: none"> ◦ Individual #7 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • Constipation <ul style="list-style-type: none"> ◦ Individual #13 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • Falls <ul style="list-style-type: none"> ◦ Individual #13 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. ◦ Individual #29 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • GERD <ul style="list-style-type: none"> ◦ Individual #13 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. ◦ Individual #41 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • Hypertension 		
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	<ul style="list-style-type: none"> ◦ Individual #41 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • Pain <ul style="list-style-type: none"> ◦ Individual #13 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • Oral Care <ul style="list-style-type: none"> ◦ Individual #29 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. ◦ Individual #16 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • Seizures <ul style="list-style-type: none"> ◦ Individual #13 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. ◦ Individual #29 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. ◦ Individual #37 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • Tube Feeding <ul style="list-style-type: none"> ◦ Individual #28 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • Crisis Plans/Medical Emergency Response Plans 		
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	<ul style="list-style-type: none"> • Aspiration <ul style="list-style-type: none"> ◦ Individual #7 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. ◦ Individual #12 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • Cerebral Shunt <ul style="list-style-type: none"> ◦ Individual #40 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • GERD <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. ◦ Individual #13 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. ◦ Individual #28 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • Falls <ul style="list-style-type: none"> ◦ Individual #29 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • Fractures <ul style="list-style-type: none"> ◦ Individual #13 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • Pain 		
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	<ul style="list-style-type: none"> ◦ Individual #13 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • Seizures <ul style="list-style-type: none"> ◦ Individual 13 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. ◦ Individual #28 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. ◦ Individual #32 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • Tube Feeding <ul style="list-style-type: none"> ◦ Individual #28 – According to the eChat summary page the individual is required to have a plan. No evidence of plan found. • Special Health Care Needs: <ul style="list-style-type: none"> • Meal Time Plan <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. • Nutritional Plan <ul style="list-style-type: none"> ◦ Individual #41 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. Other Individual Specific Evaluations & Examinations: <ul style="list-style-type: none"> • Dental Exam <ul style="list-style-type: none"> ◦ Individual #15 - As indicated by the DDSD 		
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	<p>file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found.</p> <ul style="list-style-type: none"> ◦ Individual #34 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found. ◦ Individual #36 - As indicated by the documentation reviewed, exam was completed on 8/12/2011. Follow-up was to be completed in 6 months. No documented evidence of the follow-up being completed was found. ◦ Individual #41 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found. <ul style="list-style-type: none"> • Vision Exam <ul style="list-style-type: none"> ◦ Individual #13 - As indicated by the documentation reviewed, exam was completed on 1/19/2012. Follow-up was to be completed in 3 months. No documented evidence of the follow-up being completed was found. • Prostate Specific Antigen (PSA) <ul style="list-style-type: none"> ◦ Individual #9 - As indicated by the documentation reviewed, the exam was ordered on 6/20/2011. No documented evidence of the exam being completed was found. • Blood Levels <ul style="list-style-type: none"> ◦ Individual #26 - As indicated by the 		
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	<p>documentation reviewed, lab work was ordered on 3/23/2012. No documented evidence found to verify it was completed.</p> <ul style="list-style-type: none">• Positive Behavior Support Assessment (#26 & 28)• Speech/Language Therapy Evaluation (#7)• Occupational Therapy Evaluation (#32)• Physical Therapy Evaluation (#13)		
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Tag # 1A41- Required IDT Meetings	Standard Level Deficiency		
<p>NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS:</p> <p>H. The IDT shall be convened to discuss and modify the ISP, as needed, to address:</p> <ul style="list-style-type: none"> (1) a significant life change, including a change in medical condition or medication that affects the individual's behavior or emotional state; (2) situations where an individual is at risk of significant harm. In this case the team shall convene within one working day, in person or by teleconference; if necessary, the ISP shall be modified accordingly within seventy-two (72) hours; (3) changes in any desired outcomes, (e.g. desired outcome is not met, a change in vocational goals or the loss of a job); (4) the loss or death of a significant person to the individual; (5) a serious accident, illness, injury or hospitalization that disrupts implementation of the ISP; (6) individual, guardian or provider requests for a program change or relocation, or when a termination of a service is proposed; the DDSD's policy no. 150 requires the IDT to meet and develop a transition plan whenever an individual is at risk of discharge by the provider agency or anticipates a change of provider agency to identify strategies and resources needed; if the individual or guardian is requesting a discharge or a change of provider agency, or there is an impending 	<p>Based on record review, the Agency failed to convene the IDT to discuss and/or modify the ISP and/or address significant changes as required by regulation 1 of 42 individuals.</p> <p>Review of documentation found the following IDT Meeting did not convene as required:</p> <ul style="list-style-type: none"> • Individual #16 <ul style="list-style-type: none"> ◦ As indicated by the documentation reviewed, the individual was hospitalized from 10/28/2011 – 11/3/2011. No documented evidence of IDT meetings having taken place was found. 	<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>change in housemates the team must meet to develop a transition plan;</p> <p>(7) situations where it has been determined the individual is a victim of abuse, neglect or exploitation;</p> <p>(8) criminal justice involvement on the part of the individual (e.g., arrest, incarceration, release, probation, parole);</p> <p>(9) any member of the IDT may also request that the team be convened by contacting the case manager; the case manager shall convene the team within ten (10) days of receipt of any reasonable request to convene the team, either in person or through teleconference;</p> <p>(10) for any other reason that is in the best interest of the individual, or any other reason deemed appropriate, including development, integration or provision of services that are inconsistent or in conflict with the desired outcomes of the ISP and the long term vision of the individual;</p> <p>(11) whenever the DDS decides not to approve implementation of an ISP because of cost or because the DDS believes the ISP fails to satisfy constitutional, regulatory or statutory requirements.</p>			
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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 42 individuals.</p> <p>No evidence was found of the following:</p> <ul style="list-style-type: none"> • Primary Freedom of Choice (#17) 	<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</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 1 of 42 Individuals.</p> <p>The following was found with regards to ISP Outcomes:</p> <ul style="list-style-type: none"> • Individual #36: <ul style="list-style-type: none"> ◦ "Will maintain a work study job." Outcome does not indicate how and/or when it would be completed. ◦ "Will complete household chores on his own" Outcome does not indicate how and /or when it would be completed 	<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>information to inform the IDT members and guide the development of the plan.</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>			
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Tag # 4C08 ISP Development Process	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS - F. Case Manager ISP Development Process:</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>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 42 individuals.</p> <p>Review of record found no evidence of the following:</p> <ul style="list-style-type: none"> • Case Manager Code of Ethics (#34) 	<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>(5) The Case Manager will clarify the 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"> (a) Strengths; (b) Capabilities; (c) Preferences; (d) Desires; (e) Cultural values; (f) Relationships; (g) Resources; (h) Functional skills in the community; (i) Work interests and experiences; (j) Hobbies; (k) Community membership activities or interests; (l) Spiritual beliefs or interests; and (m) Communication and learning styles or preferences to be used in development of the individual's service plan. <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</p>			
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<p>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 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 DDSD Decision Justification form.</p> <p>(c) In the context of employment, informed choices include the following:</p> <ul style="list-style-type: none"> (i) Information regarding the range of employment options available to the individual (ii) Information regarding self-employment and customized employment options (iii) Job exploration activities including volunteer work and/or trial work opportunities <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.</p>			
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<p>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>			
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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 Freedom of Choice documentation and ensure individuals obtained all services through the Freedom of Choice Process for 3 of 42 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"> ◦ Supported Living (#17) ◦ Adult Habilitation (#17) ◦ Community Access (#36) ◦ Behavior Consultation (17) ◦ Physical Therapy (#13 & 36) 	<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 # 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</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 14 of 42 individuals.</p> <p>The following quarterly/bi-annual reports were not found:</p> <ul style="list-style-type: none"> • Supported Living Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #9 - None found for January 2012 – March 2012. ◦ Individual #13 – None found for April 2011 – December 2011. ◦ Individual #28 – None found for April 2011 – April 2012. • Family Living Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #2 – None found for January 2012 – March 2012. ◦ Individual #14 – None found for March 11 – May 2011. ◦ Individual #36 – None found for October 2011 – December 2011. • Community Inclusion - Adult Habilitation Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #8 – None found for April 2011 – June 2011. ◦ Individual #13 – None Found for April 2011 – June 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>date.</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</p>	<ul style="list-style-type: none"> ◦ Individual #14 – None found for April 2011 – September 2011. ◦ Individual #20 – None found for April 2011 – April 2012. ◦ Individual #26 – None found for August 2011 – October 2011. ◦ Individual #34 – None found for January 2012 – March 2012. <p>• Community Inclusion - Community Access Quarterly Reports:</p> <ul style="list-style-type: none"> ◦ Individual #34 – None found for January 2012 – March 2012. ◦ Individual #35 – None found for July 2011 – March 2012. ◦ Individual #36 – None found for October 2011 – December 2011. <p>• Community Inclusion - Community Access Annual Assessment:</p> <ul style="list-style-type: none"> ◦ Individual #34 – None found for December 2010 – December 2011. <p>• Community Inclusion - Supported Employment Quarterly Reports:</p> <ul style="list-style-type: none"> ◦ Individual #26 – None found for August 2011 – October 2011. ◦ Individual #34 – None found for January 2012 – March 2012. <p>• Behavior Consultation Quarterly Reports:</p>		
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<p>levels of community integration. These activities do not need to be limited to paid supports but may include independent or leisure activities appropriate to the individual.</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</p>	<ul style="list-style-type: none"> ◦ Individual #9 – None found for May 2011 – April 2012. ◦ Individual #28 – None found for April 2011 – March 2012. <p>• Speech & Language Pathology Bi-Annual Progress Reports:</p> <ul style="list-style-type: none"> ◦ Individual #28 – None found for October 2011 – April 2012. <p>• Occupational Bi-Annual Progress Reports:</p> <ul style="list-style-type: none"> ◦ Individual #8 – None found for August 2011 – January 2012. ◦ Individual #32 – None found for April 2011 – April 2012. <p>• Physical Bi-Annual Progress Reports:</p> <ul style="list-style-type: none"> ◦ Individual #13 – None found for August 2011 – January 2012. ◦ Individual #35 – None found for September 2011 – February 2012. <p>• Quarterly Nursing Review of HCP/MERPS</p> <ul style="list-style-type: none"> ◦ Individual #13 – None found for March 2011 – November 2011. ◦ Individual #14 – None found for March 2011 – May 2011. ◦ Individual # 16 – None found for July 2011 – September 2011. ◦ Individual # 28 – None found for April 2011 – June 2011. 		
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<p>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 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 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.</p>	<ul style="list-style-type: none"> ◦ Individual #35 – None found for April 2011 – September 2011. ◦ Individual #41 – None found for June 2011 - February 2012 		
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Level of Care – Initial and annual Level of Care (LOC) evaluations are completed within timeframes specified by the State.			
Tag # 4C04 Assessment Activities	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>B. Case Management Assessment Activities: 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</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 42 individuals.</p> <p>The following items were not found and/or incomplete:</p> <ul style="list-style-type: none"> • Annual Physical (9) 	<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>Department (HSD) has completed a determination that the individual meets financial and medical eligibility to participate in the DD Waiver program.</p> <p>(3) Provide a copy of the MAW letter to service providers listed on the ISP budget (MAD 046).</p>			
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Tag # 4C05 Review & Approval of the LTCAA by NMMUR	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</p> <p>C. Review and Approval of the LTCAA by the New Mexico Medicaid Utilization Review (NMMUR) Agent</p> <p>(1) The Case Manager will submit the LTCAA packet to the NMMUR agent for review and approval. If it is an initial allocation, submission shall occur within 60 days from the date the DDSD receives the individual's allocation letter for the DD Waiver. For re-determinations, submission shall occur between 45 days and 30 days prior to the ISP expiration date.</p> <p>(2) Prior to service delivery, the NMMUR agent shall approve:</p> <p>(a) All initial LTCAAs;</p> <p>(b) Any LTCAAs that result in a change in the level of care for the individual; and</p> <p>(c) Any re-admit LTCAAs to the DD Waiver.</p> <p>(3) In addition to initial allocations, the NMMUR agent reviews and approves the LTCAA every three years for individuals on the Waiver.</p> <p>(4) The Case Manager shall respond to</p>	<p>Based on record review, the Agency failed to maintain documentation of NMMUR review and approval of LTCAA for 1 of 42 individuals.</p> <p>The following items were not found, incomplete and/or not current:</p> <p>Re-Admit:</p> <ul style="list-style-type: none"> • Level of Care (#16) 	<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>NMMUR within specified timelines when the LTCAA packet is returned for corrections or additional information.</p>			
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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 – <i>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.</i></p>			
<p>Tag # 1A26 Consolidated On-line Registry / Employee Abuse Registry</p>	<p>Standard Level Deficiency</p>		
<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</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 1 of 16 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"> • #49 – Date of Hire 5/15/2010. Completed on 6/11/2010. 	<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>exploitation of a person receiving care or services from a provider.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. Documentation for other staff. With 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>			
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<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>Chapter 1.IV. General Provider Requirements. D. Criminal History</p> <p>Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.</p>			
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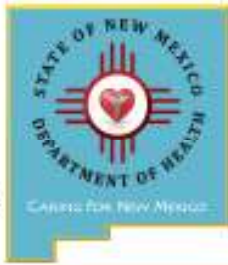
Tag # 4C17 Case Manager Qualifications - Required Training	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</p> <p>E. Case Manager Qualifications: Case Managers, whether subcontracting 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 DDSD 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 DDSD 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 DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; and</p> <p>(b) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, or agency position changes, and name changes.</p> <p>Department of Health (DOH)</p>	<p>Based on record review, the Agency failed to ensure that Training requirements were met for 3 of 16 Case Managers.</p> <p>Review of Case Manager training records found no evidence of the following required DOH/DDSD trainings being completed:</p> <ul style="list-style-type: none"> • Pre-Service Manual (#54) • Person-Centered Planning in New Mexico (2-Days) (#53) • Promoting Effective Teamwork (#46 & 53) 	<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>Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Case Management Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</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 course, trainees shall achieve 100% competency rating during the competency verification process.</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 # 4C21 Case Management Reimbursement</p>	<p>Standard Level Deficiency</p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. MAD-MR: 03-59 Eff 1/1/2004</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed, which contained the required information for 1 of 42 individuals.</p> <p>Individual #38 August 2011</p> <ul style="list-style-type: none"> The Agency billed 1 unit of Case Management (T2022) on 8/8/2011. Documentation did not contain start and end time to justify 1 unit billed. <p>September 2011</p> <ul style="list-style-type: none"> The Agency billed 1 unit of Case Management (T2022) on 9/24/2011. Documentation did not contain start and end time to justify 1 unit billed. <p>October 2011</p> <ul style="list-style-type: none"> The Agency billed 1 unit of Case Management (T2022) on 10/28/2011. Documentation did not contain start and end time to justify 1 unit billed. <p>November 2011</p> <ul style="list-style-type: none"> The Agency billed 1 unit of Case Management (T2022) on 11/6/2011. Documentation did not contain start and end time to justify 1 unit billed. 	<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>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4. V. CASE MANAGEMENT SERVICES REIMBURSEMENT - A. Billable Unit</p> <p>(1) Reimbursement to the Case Management Provider Agency is based upon a monthly rate for a maximum of 12 months per ISP year.</p> <p>(2) The Case Management Provider Agency shall provide and document at least one hour of case management services per individual served, and a monthly average of at least three (3) hours of DD Waiver service per individual, including face-to-face contacts, across the caseload of each Case Manager. A Case Management Provider Agency cannot bill for an individual for whom a face-to-face contact did not take place during the month.</p> <p>(3) Exceptions to the three-hour average are allowed if the Case Manager is on approved leave, as long as a Provider Agency colleague or supervisor has maintained essential duties during his or her absence, including mandated face-to-face visits.</p> <p>(4) Partial units are paid when the individual transitions from one Case Management Provider</p>	<p>December 2011</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Case Management (T2022) on 12/28/2011. Documentation did not contain start and end time to justify 1 unit billed. <p>January 2012</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Case Management (T2022) on 1/5//2012. Documentation did not contain start and end time to justify 1 unit billed. <p>March 2012</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Case Management (T2022) on 3/29/2012. Documentation did not contain start and end time to justify 1 unit billed. <p>April 2012</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Case Management (T2022) on 4/4/2012. Documentation did not contain start and end time to justify 1 unit billed. 		
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<p>Agency to another during the month, and a Case Manager provides at least one hour of billable service including face-to-face contact during that calendar month. The monthly rate is pro-rated based on the number of days the individual was with the Case Management Provider Agency.</p> <p>B. Billable Services: The following activities are deemed to be billable services:</p> <p>(1) All services and supports within the Case Management Scope of Services; and</p> <p>(2) Case Management may be provided at the same time on the same day as any other service.</p>			
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SUSANA MARTINEZ, GOVERNOR

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

Date: October 4, 2012

To: Sherrie Binkley, Executive Director
Provider: Peak Developmental Services, Inc.
Address: 3500 Comanche Rd, NE Suite C
State/Zip: Albuquerque, New Mexico, 87107

E-mail Address: peakcm@gmail.com

Region: Metro & Northwest
Survey Date: June 4 – 7, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Case Management
Survey Type: Routine

Dear Mrs. Binkley,

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.13.1.DDW.D2793.1&5.001.RTN.09.278



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