

Date: September 10, 2013

To: Sherry Moore-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

CC: Sarah Heartsong, Case Manager Supervisor/Case Manager
 Address: 1165 Commerce, Ste B
 State/Zip: Las Cruces, New Mexico 88001

Region: Southwest
 Survey Date: July 29 - 31, 2013
 Program Surveyed: Developmental Disabilities Waiver
 Service Surveyed: Case Management
 Survey Type: Routine
 Team Leader: Amanda Castañeda, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Mari Chavez, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau and Deb Russell, BS, Division of Health Improvement/Quality Management Bureau

Dear Ms. 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.

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.



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

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,

Amanda Castañeda, MPA

Amanda Castañeda, MPA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

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:
 - 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.”

QMB Report of Findings – Peak Developmental Services, Inc. - Southwest Region – July 29 – August 1, 2013

- 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.

Attachment B

Department of Health, Division of Health Improvement QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Management system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on the provider's compliance or non-compliance with standards and regulations identified in the QMB Report of Findings. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Within the QMB Service Domains there are fundamental regulations, standards, or policies with which a provider must be in essential compliance in order to ensure the health and welfare of individuals served known as Conditions of Participation (CoPs).

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in three (3) Service Domains.

Case Management Services:

- Level of Care,
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

- Qualified Provider,
- Plan of Care,
- Health, Welfare & Safety

Conditions of Participation (CoPs)

A CoP is an identified fundamental regulation, standard, or policy with which a provider must be in compliance in order to ensure the health and welfare of individuals served. CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances. A provider must be in compliance with CoPs to participate as a waiver provider.

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP. (See the next section for a list of CoPs.) The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

CoPs and Service Domains for Case Management Supports are as follows:

Service Domain: Level of Care

Condition of Participation:

1. **Level of Care:** The Case Manager shall complete all required elements of the Long Term Care Assessment Abstract (LTCAA) to ensure ongoing eligibility for waiver services.

Service Domain: Plan of Care

Condition of Participation:

2. **Individual Service Plan (ISP) Creation and Development:** Each individual shall have an ISP. The ISP shall be developed in accordance with DDSD regulations and standards and is updated at least annually or when warranted by changes in the individual's needs.

Condition of Participation:

3. **ISP Monitoring and Evaluation:** The Case Manager shall ensure the health and welfare of the individual through monitoring the implementation of ISP desired outcomes.

CoPs and Service Domain for ALL Service Providers is as follows:

Service Domain: Qualified Providers

Condition of Participation:

4. **Qualified Providers:** Agencies shall ensure support staff has completed criminal background screening and all mandated trainings as required by the DDSD.

CoPs and Service Domains for Living Supports and Inclusion Supports are as follows:

Service Domain: Plan of Care

Condition of Participation:

5. **ISP Implementation:** Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

Service Domain: Health, Welfare & Safety

Condition of Participation:

6. **Individual Health, Safety and Welfare: (Safety) Individuals have the right to live and work in a safe environment.**

Condition of Participation:

7. **Individual Health, Safety and Welfare (Healthcare Oversight):** The provider shall support individuals to access needed healthcare services in a timely manner. Nursing, healthcare services and healthcare oversight shall be available and provided as needed to address individuals' health, safety and welfare.

QMB Compliance Determinations

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). 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 in all relevant Service Domains. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) out of compliance in any of the Service Domains.

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 Conditions of Participation in one (1) to two (2) Service Domains. The agency may have one or more Condition level tags within a Service Domain. 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) in any of the Service Domains.

Providers receiving a repeat determination of Partial-Compliance for repeat deficiencies at the level of a Condition in any Service Domain may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

Non-Compliance 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 in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains. This non-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) in any of the Service Domains

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 or sanctions.

**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 received 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 written 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 received 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 - Southwest Region
Program: Developmental Disabilities Waiver
Service: Case Management
Monitoring Type: Routine Survey
Survey Date: July 29-31, 2013

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>Service Domain: Plan of Care - ISP Development & Monitoring – Service plans address all participants’ assessed needs(including health and safety risk factors) and goals, either by waiver services or through other means. Services plans are updated or revised at least annually or when warranted by changes in the waiver participants’ needs.</p>			
<p>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 did not maintain a complete and confidential case file at the administrative office for 14 of 25 individuals.</p> <p>Review of the Agency individual case files revealed 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 Found (#6) • ISP Assessment Checklist Appendix 1 (#3, 6, 10, 20) • Individual Specific Training Section (ISP) (#6) • ISP Teaching & Support Strategies <ul style="list-style-type: none"> ◦ Individual #5 - TSS not found for: ◦ Work/Learn Outcome Statement: "...will create a portfolio/or collage of things she likes." <ul style="list-style-type: none"> ➢ "... will choose items that she wants to put into her portfolio, one time per week." 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</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 from Los Lunas Hospital and Training</p>	<ul style="list-style-type: none"> ◦ Work/Learn Outcome Statement Outcome Statement: "...will participate in an educational activity for the rest of the year." <ul style="list-style-type: none"> ➢ "...will participate in the activity, once a week." ◦ <i>Individual #12 - TSS not found for:</i> ◦ Develop Relationships/Have Fun Outcome Statement: "...will make one purchase independently during each CA outing." <ul style="list-style-type: none"> ➢ "...will make one small purchase during each community access outing weekly." ◦ <i>Individual #13 - TSS not found for:</i> ◦ Work/Learn Outcome Statement: "He will complete 6 canvas paintings in the next 12 months." <ul style="list-style-type: none"> ➢ "...will need to purchase the items needed one time." ➢ "...will paint on his canvas free hand, 6 paintings in 12 months." • Positive Behavioral Plan (#20) • Positive Behavioral Crisis Plan (#20) • Speech Therapy Plan (#3, 25) • Occupational Therapy Plan (#10, 24) • Physical Therapy Plan (#6, 19, 20) <i>**Note: No Plan of Correction required for Individual #19. Due Diligence was evident.</i> • Electronic Comprehensive Health Assessment Tool (#6, 10, 20) • Health Care Plans <ul style="list-style-type: none"> • <i>Aspiration Risk</i> ◦ Individual #6 - According to the Electronic 		
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<p>School or Ft. Stanton Hospital.</p>	<p>Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found.</p> <ul style="list-style-type: none"> ◦ Individual #10 - According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. ◦ Individual #20 - According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. <ul style="list-style-type: none"> • <i>Bowel and Bladder</i> <ul style="list-style-type: none"> ◦ Individual #3 - According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. • <i>Complains of or demonstrates signs/symptoms of reflux</i> <ul style="list-style-type: none"> ◦ Individual #20 - According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. • <i>Constipation Management</i> <ul style="list-style-type: none"> ◦ Individual #6 – According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. ◦ Individual #20 – According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. • <i>Respiratory</i> <ul style="list-style-type: none"> ◦ Individual #20 - According to the Electronic Comprehensive Health Assessment Tool, 		
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	<p>the Individual is required to have a plan. No evidence of plan found.</p> <ul style="list-style-type: none"> • <i>Status of Oral Care/Hygiene</i> <ul style="list-style-type: none"> ◦ Individual #10 - According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. ◦ Individual #20 - According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. • <i>Seizure Disorder</i> <ul style="list-style-type: none"> ◦ Individual #20 - According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. • <i>Skin and Wound</i> <ul style="list-style-type: none"> Individual #10 – According to the Electronic Comprehensive Health Assessment Tool, 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"> • <i>Aspiration Risk</i> <ul style="list-style-type: none"> ◦ Individual #6 - According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. ◦ Individual #10 - According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. ◦ Individual #20 - According to the Electronic Comprehensive Health Assessment Tool, 		
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	<p>the Individual is required to have a plan. No evidence of plan found.</p> <ul style="list-style-type: none"> • <i>Constipation Management</i> <ul style="list-style-type: none"> ◦ Individual #6 – According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. ◦ Individual #20 – According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. • <i>Respiratory</i> <ul style="list-style-type: none"> ◦ Individual #20 – According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. • <i>Seizure Disorder</i> <ul style="list-style-type: none"> ◦ Individual #20 - According to the Electronic Comprehensive Health Assessment Tool, the Individual is required to have a plan. No evidence of plan found. • Neurological Evaluation <ul style="list-style-type: none"> ◦ Individual #13 - Per documentation reviewed, evaluation was completed on 8/24/2012. Follow-up was to be completed in 6 months. No documented evidence of the evaluation being completed was found. • Dental Exam <ul style="list-style-type: none"> ◦ Individual #9 - As indicated by the DDS file matrix, Dental Exams are to be conducted annually. No documented evidence of exam was found. ◦ Individual #10 - As indicated by the documentation reviewed, exam was 		
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	<p>completed on 6/5/2012. Follow-up was to be completed in 6 months. No documented evidence of the follow-up being completed was found.</p> <ul style="list-style-type: none"> ◦ Individual #16 - As indicated by the documentation reviewed, exam was completed on 10/29/2012. Follow-up was to be completed in 6 months. No documented evidence of the follow-up being completed was found. ◦ Individual #20 - As indicated by the DDS file matrix, Dental Exams are to be conducted annually. No documented evidence of exam was found. <ul style="list-style-type: none"> • Auditory Exam <ul style="list-style-type: none"> ◦ Individual #10 - As indicated by the documentation reviewed, exam was completed on 4/9/2012. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. • Vision Exam <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the DDS file matrix, Vision Exams are to be conducted every other year. No documented evidence of exam was found. ◦ Individual #25 - As indicated by the DDS file matrix, Vision Exams are to be conducted every other year. No documented evidence of exam was found. • Pap Smear Exam <ul style="list-style-type: none"> ◦ Individual #7 - As indicated by the documentation reviewed, the exam was recommended on 9/27/2012 by PCP. No documented evidence of the exam being 		
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	<p>completed was found.</p> <ul style="list-style-type: none"> • Bone Density Exam <ul style="list-style-type: none"> ◦ Individual #21 - As indicated by the documentation reviewed, the exam was recommended on 7/25/2012 by PCP. No documented evidence of the exam being completed was found. ▪ Cholesterol & Blood Glucose <ul style="list-style-type: none"> ◦ Individual #13 - As indicated by the documentation reviewed, lab work was ordered on 10/26/2012. No documented evidence was found to verify it was completed. ◦ Individual #21 - As indicated by the documentation reviewed, lab work was ordered on 7/25/2012. No documented evidence was found to verify it was completed. • Blood Levels <ul style="list-style-type: none"> ◦ Individual #13 - As indicated by the documentation reviewed, lab work was ordered on 10/26/2012. No documented evidence found to verify it was completed. • Positive Behavior Support Assessment (#20) • Physical Therapy Evaluation (#19, 20) <i>**Note: No Plan of Correction required for Individual #19. Due Diligence was evident.</i> 		
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<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"> • Individual #20: <ul style="list-style-type: none"> ◦ "Greet people every time they come visit." Outcome does not indicate how and/or when it would be completed. ◦ "Increase his tolerance during community events." Outcome does not indicate how and/or when it would be completed. ◦ "Assist with serving refreshments during social gatherings." Outcome does not indicate how and/or when it would be completed. • Individual #25: <ul style="list-style-type: none"> ◦ "...will greet people by name when they come visit at home." Outcome does not indicate how and/or when it would be completed. ◦ "...will communicate his needs by using simple sentences." Outcome was does not indicate how and/or when it would be completed. ◦ "...will explore an activity in the community." Outcome was does not indicate how and/or when it would be completed. 		
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<p>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 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>			
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<p>(b) In cases when employment is not an immediate desired outcome, the ISP shall document the reasons for this decision and develop employment-related goals within the ISP that will be undertaken to explore employment options (e.g., volunteer activities, career exploration, situational assessments, etc.) This discussion related to employment issues shall be documented within the ISP or on the DDS Decision Justification form.</p> <p>(c) In the context of employment, informed choices include the following:</p> <ul style="list-style-type: none"> (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. 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</p>			
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<p>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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<p>members and who do not receive Community Living Services, at least one face-to-face visit per quarter shall be in his or her home;</p> <p>(e) If concerns regarding the health or safety of the individual are documented during monitoring or assessment activities, the Case Manager shall immediately notify appropriate supervisory personnel within the Provider Agency and document the concern. If the reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office and/or the Division of Health Improvement (DHI) as appropriate to the nature of the concern. Unless the nature of the concern is urgent, no more than fifteen (15) working days shall be allowed for remediation or development of an acceptable plan of remediation. This does not preclude the Case Managers' obligation to report abuse, neglect or exploitation as required by New Mexico Statute.</p> <p>(f) Service monitoring for children: When a parent chooses fewer than twelve (12) annual units of case management, the Case Manager will inform the parent of the parent's responsibility for the monitoring and evaluation activities during the months he or she does not receive case management services,</p> <p>(g) It is appropriate to conduct face-to-face visits with the individual both during the time the individual is receiving a service and during times the individual is not</p>			
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<p>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>(ii) If the quarterly report is not received</p>	<p>Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 10 of 25 individuals.</p> <p>Review of the Agency individual case files revealed no evidence of quarterly/bi-annual reports for the following:</p> <ul style="list-style-type: none"> • Supported Living Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #9 – None found for April 2013 – June 2013. • Family Living Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #3 – None found for April 2013 – June 2013. ◦ Individual #6 – None found for April 2013 and May 2013. <i>Note: Agency completes monthly reports in lieu of quarterlies.</i> ◦ Individual #10 – None found for May 2013 and June 2013. <i>Note: Agency completes monthly reports in lieu of quarterlies.</i> ◦ Individual #20 – None found for February 2013, March 2013, May 2013, and June 2013. <i>Note: Agency completes monthly reports in lieu of quarterlies.</i> • Family Living Annual Assessment <ul style="list-style-type: none"> ◦ Individual #3 – None found for September 2011 – September 2012. ◦ Individual #5 – None found for October 2011 – October 2012. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>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 individual.</p>	<ul style="list-style-type: none"> ◦ Individual #6 – None found for September 2011 – September 2012. ◦ Individual #10 – None found for September 2011 – September 2012. ◦ Individual #13 – None found for December 2011 – November 2012. ◦ Individual #20 – None found for October 2011 – October 2012. <p>• Community Inclusion - Adult Habilitation Quarterly Reports:</p> <ul style="list-style-type: none"> ◦ Individual #5 – None found for April 2012 – September 2012. ◦ Individual #9 – None found for April 2013 - June 2013. <p>• Community Inclusion - Community Access Quarterly Reports:</p> <ul style="list-style-type: none"> ◦ Individual #6 – None found for April 2013 and May 2013. <i>Note: Agency completes monthly reports in lieu of quarterlies.</i> ◦ Individual #20 – None found for May 2013 and June 2013. <i>Note: Agency completes monthly reports in lieu of quarterlies.</i> <p>• Community Inclusion - Community Access Annual Assessment:</p> <ul style="list-style-type: none"> ◦ Individual #6 – None found for September 2011 – September 2012. ◦ Individual #13 – None found for December 2011 – November 2012. ◦ Individual #20 – None found for October 2011 – October 2012. 		
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<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 Provider Agencies are required to promote and comply with the Case Management</p>	<ul style="list-style-type: none"> • Speech & Language Pathology Bi-Annual Progress Reports: <ul style="list-style-type: none"> ◦ Individual #3 – None found for October 2012 – March 2013. ◦ Individual #9 – None found for October 2012 – March 2013. • Occupational Bi-Annual Progress Reports: <ul style="list-style-type: none"> ◦ Individual #2 – None found for September 2012 – February 2013. ◦ Individual #9 – None found for September 2012 – February 2013. • Physical Bi-Annual Progress Reports: <ul style="list-style-type: none"> ◦ Individual #6 – None found for September 2012 – March 2013. ◦ Individual #10 – None found for November 2012 – May 2013. ◦ Individual #20 – None found for October 2012 – April 2013. ◦ Individual #25 – None found for November 2012 – May 2013. • Nursing Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #21 – None found for July 2012 – October 2012. 		
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<p>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>			
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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 # 1A28.1 Incident Mgt. System - Personnel Training</p>	<p>Standard Level Deficiency</p>		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p>	<p>Based on record review and interview, the Agency did not provide documentation verifying completion of Incident Management Training for 8 of 9 Agency Personnel.</p> <ul style="list-style-type: none"> Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#51, 52, 53, 54, 55, 56, 57, 58) <p><i>Note: Trainings Expired 7/17/2013, 7/18/2013, 7/27/2013.</i></p>	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007

II. POLICY STATEMENTS:

A. Individuals shall receive services from competent and qualified staff.

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

<p>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 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>documentation was found to justify 1 unit billed.</p>		
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<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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Date: December 03, 2013

To: Sherry Moore-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

CC: Sarah Heartsong, Case Manager Supervisor/Case Manager
Address: 1165 Commerce, Ste B
State/Zip: Las Cruces, New Mexico 88001
E-Mail Address: heartsongwoman@gmail.com

Region: Southwest
Survey Date: July 29 - 31, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Case Management
Survey Type: Routine

Dear Ms. 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.

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 of 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.14.2.DDW.D2793.3.001.RTN.09.337