Date: August 27, 2010

To: Monica Enox, Case Management Supervisor/Owner
Provider: Purple Cow Case Management, LLC
Address: 105 West 3rd Street
State/Zip: Roswell, NM 88201

E-mail Address: m_enox@hotmail.com

CC: Ronald Tucker, Case Manager/Owner
Address: 105 West 3rd Street
State/Zip: Roswell, NM 88201

Boardchair E-Mail Address: dbacinci@hotmail.com

Region: Southeast
Survey Date: July 7 – 12, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Case Management
Survey Type: Routine
Team Leader: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Juana Bravo, BA, Jackson Compliance Team, Developmental Disabilities Support Division/ Southeast Regional Office

Dear Ms. Enox,

The Division of Health Improvement/Quality Management Bureau has completed a quality review survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement.

Quality Management Approval Rating:
The Division of Health Improvement is issuing your agency a determination of "Non-Compliance with Conditions of Participation."

Plan of Correction:
The attached Report of Findings identifies deficiencies found during your agency's survey. You are required to complete and implement a Plan of Correction (POC). Please submit your agency's Plan of Correction (POC) in the space on the two right columns of the Report of Findings. See attachment A for additional guidance in completing the POC. The response is due to the parties below within 10 working days of the receipt of this letter:

1. Quality Management Bureau, Attention: Plan of Correction Coordinator
   5301 Central Ave. NE Suite 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 within 45 working days. If your plan of correction is denied, you must resubmit a revised plan ASAP for approval. All remedies must still be completed within 45 working days of the original submission.

Failure to submit, complete or implement your POC within the required time frames will result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Request for Informal Reconsideration of Findings (IRF):
If you disagree with a determination of noncompliance (finding) you have 10 working days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

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

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

If the IRF approves the change or removal of a finding, you will be advised of any changes.

This IRF process is separate and apart from the Informal Dispute Resolution (IDR) and Fair Hearing Process for Sanctions from DOH.

Please call the Team Leader at 505-690-4693, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Deb Russell, BS

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

Survey Process Employed:

Entrance Conference Date:	July 7, 2010
Present:	**Purple Cow Case Management, LLC** Ron Tucker, Case Manager/Owner **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor **DDSD - Southeast Regional Office** Juana Bravo, BA, Jackson Compliance Team
Exit Conference Date:	July 8, 2010
Present:	**Purple Cow Case Management, LLC** Ron Tucker, Case Manager/Owner Monica Enox, Case Management Supervisor/Owner Lonna Enox, Case Manager/Owner **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor **DDSD - Southeast Regional Office** Juana Bravo, BA, Jackson Compliance Team
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 9 1 - Jackson Class Members 8 - Non-Jackson Class Members
Case Manager Personnel Record Review:	Number: 3
Case Managers Interviewed	Number: 3
Records Reviewed (Persons Served)	Number: 9
Administrative Files Reviewed	• Billing Records • Incident Management Records • Personnel Files • Training Records • Agency Policy and Procedure • Caregiver Criminal History Screening Records • Employee Abuse Registry • Quality Improvement/Quality Assurance Plan

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

Attachment A

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8647.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency ("Responsible Party"), and by WHEN ("Date Due").
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency's Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-222-8661), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been "Approved" or "Denied".
- Whether your POC is "Approved" or "Denied", you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is "Denied" it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8647 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual numbers.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Attachment B

QMB Scope and Severity Matrix of survey results

Each deficiency in your Report of Findings is scored on a Scope and Severity Scale. The culmination of each deficiency's Scope and Severity is used to determine degree of compliance to standards and regulations and level of QMB Certification.

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

Scope and Severity Definitions:

Key to Scope scale:
Isolated:
A deficiency that is limited to 1% to 15% of the sample, usually impacting no more than one or two individuals in the sample.

Pattern:
A deficiency that impacts a number or group of individuals from 16% to 79% of the sample is defined as a pattern finding. Pattern findings suggest the need for system wide corrective actions.

Widespread:
A deficiency that impacts most or all (80% to 100%) of the individuals in the sample is defined as widespread or pervasive. Widespread findings suggest the need for system wide corrective actions as well as the need to implement a Continuous Quality Improvement process to improve or build infrastructure. Widespread findings must be referred to the Internal Review Committee for review and possible actions or sanctions.

Key to Findings:

"Substantial Compliance with Conditions of Participation"
The QMB determination of "Substantial Compliance with Conditions of Participation" indicates that a provider is in substantial compliance with all 'Conditions of Participation' and other standards and regulations. 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 Substantial Compliance with Conditions of Participation, the provider must not have any findings that meet the thresholds for determining non-compliance with any Condition of Participation.

"Non-Compliance with Conditions of Participation"
The QMB determination of "Non-Compliance with Conditions of Participation" indicates that a provider is out of compliance with one (1) or more 'Conditions of Participation.' This non-compliance, if not corrected, is likely to result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety.

Providers receiving a repeat determination of Non-Compliance may be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

"Sub-Standard Compliance with Conditions of Participation":
The QMB determination of "Sub-Standard Compliance with Conditions of Participation" indicates a provider is significantly out of compliance with Conditions of Participation and/or has:

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.

Providers receiving a repeat determination of 'Substandard Compliance' will be referred by QMB 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 process, surveyors are openly communicating with providers. Open communication means that surveyors have clarified issues and/or requested missing information before completing the review. Regardless, there may still be instances where the provider disagrees with a specific finding.

To informally dispute a finding the provider must request in writing an Informal Reconsideration of the Finding (IRF) to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.

The written request for an IRF **must be completed on the QMB Request for Informal Reconsideration of Finding Form** (available on the QMB website: http://dhi.health.state.nm.us/qmb) and must specify in detail the request for reconsideration and why the finding is inaccurate. The **IRF request must include all supporting documentation or evidence that was not previously reviewed during the survey process.**

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received in 10 days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed by the survey team.
- Providers must continue to complete their plan of correction during the IRF process
- Providers may not request an IRF to challenge the Scope and Severity of a finding.
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition
- Providers may not request an IRF to challenge the QMB Quality Approval Rating and the length of their DDSD provider contract.

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

QMB has 30 working days to complete the review and notify the provider of the decision. The request will be reviewed by the IRF committee. The Provider will be notified in writing of the ruling, no face to face meeting will be conducted.

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

Agency: **Purple Cow Case Management, LLC - Southeast Region**
Program: Developmental Disabilities Waiver
Service: Case Management
Monitoring Type: Routine Survey
Date of Survey: **July 7 – 12, 2010**

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A08 Agency Case File	**Scope and Severity Rating: B**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual,	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 7 of 9 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current: • ISP Assessment Checklist (#1, 2, 4, 5 & 8) • Addendum A (#4) • **ISP Teaching & Support Strategies** ° Individual #5 - TASS not found for: ➢ Get a raise ➢ Host a party • Positive Behavioral Plan (#7) • Occupational Therapy Plan (#2) • Health Assessment Tool (#4) **Other Individual Specific Evaluations & Examinations:** • **Dental Exam** ° Individual #3 - As indicated by the ISP Assessment Checklist, the exam was to be completed "ASAP." No evidence of exam was found.		

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: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.	• **Health Care Plans** • HAT Score Level 5 ° Individual #8 - According to Health Assessment Tool core, the individual is required to have a plan. • **Crisis Plans** • Choking Risk ° Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Allergies ° Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. • Vocational Assessment Profile (#4 & 5) • Career Development Plan (#4) • Occupational Therapy Evaluation (#2) • Guardianship Documentation (#3)		

Tag # 1A28 (CoP) Incident Mgt. System - Policy & Procedure	Scope & Severity Rating: F		
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **C. Incident Policies:** All community based service providers shall maintain policies and procedures, which describe the community based service provider's immediate response to all reported allegations of incidents involving abuse, neglect, or misappropriation of property; all unexpected deaths or natural/expected deaths, and other reportable incidents required as required in Paragraph (2) of Subsection A of 7.1.13.9 NMAC. **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. **B. Training Curriculum:** The licensed health care facility and community based service provider shall provide all employees and volunteers with a written training curriculum on incident policies and procedures for identification, and timely reporting of abuse, neglect, misappropriation of consumers' property, and where applicable to community based service providers, unexpected deaths or other reportable incidents, within thirty (30) days of the employees' initial employment, and by annual review not to exceed twelve (12) month intervals. The training curriculum may include computer-	Based on record review and interview, the Agency failed to establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. During on-site survey, the following was found: • No Incident Management System Policies and Procedures specific to the Agency. When #42 was asked if the Agency had established policies and procedures regarding incident management, #42 stated, "We use the current Incident Management Guide. There is not a separate policy."		

based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the licensed health care facilities or community based service provider's facility. Training shall be conducted in a language that is understood by the employee and volunteer. **C. Incident Management System Training Curriculum Requirements:** **(1)** The licensed health care facility and community based service provider shall conduct training, or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, misappropriation of consumers' property; **(b)** informational procedures for properly filing the division's incident management report form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and misappropriation of consumers' property. **(d)** specific instructions on how to respond to abuse, neglect, misappropriation of consumers' property; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, misappropriation of consumers' property; and **(f)** where applicable to employees of community based service providers, informational procedures for properly filing the division's incident management report form for unexpected deaths or other reportable incidents.			

Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: B		
NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure	Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 2 of 9 individuals. • Grievance/Complaint Procedure Acknowledgement (#3 & 7)		

Tag # 4C07 - Individual Service Planning	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS** **E. Individualized Service Planning and Approval:** (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: (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: (i) An ongoing process, based on the individual's long-term vision, and not a one-time-a-year event; and (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.). (2) The Case Manager will ensure the ongoing assessment of the individual's strengths, needs and preferences and use this information to inform the IDT members and guide the development of the plan.	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 2 of 9 Individuals. The following was found with regards to ISP Outcomes: • Individual #2: "Volunteer is to be completed 1 time per week." Outcome does not indicate how and/or when it would be completed. • Individual #2: "Exercise at the gym is to be completed 1 time per week." Outcome does not indicate how and/or when it would be completed. • Individual #5: "Host party is to be completed 1 time per month." Outcome does not indicate how and/or when it would be completed. • Individual #5: "Swim at racquet club is to be completed 2 times per month." Outcome does not indicate how and/or when it would be completed.		

Tag # 4C08 (CoP) - ISP Development Process	Scope and Severity Rating: F		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS - F. Case Manager ISP Development Process:** (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. (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. (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). (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. (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	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 8 of 9 individuals. Review of record found no evidence of the following: • Rights & Responsibilities (#1, 2, 3, 4, 5, 6, 7 & 9) • Case Manager Code of Ethics (#7)		

not limited to the following: (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. (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. (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. (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. (c) In the context of employment, informed choices include the following: (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 (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. (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. (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. (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. (11) The Case Manager shall complete the initial ISP development within ninety (90) days as required by DDSD.			

Tag # 4C09 - Secondary FOC	Scope and Severity Rating: B		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS** **G. Secondary Freedom of Choice Process** (1) The Case Management Provider Agency will ensure that it maintains a current Secondary Freedom of Choice (FOC) form that includes all service providers offering services in that region. (2) The Case Manager will present the Secondary FOC form to the individual or authorized representative for selection of direct service providers. (3) At least annually, at the time rights and responsibilities are reviewed, individuals and guardians served will be reminded that they may change providers at any time, as well as change types of services. At this time, Case Managers shall offer to review the current Secondary FOC list with individuals and guardians served. If they are interested in changing, a new FOC shall be completed.	Based on record review, the Agency failed to maintain current Secondary Freedom of Choice documentation and ensure individuals obtained all services through the Freedom of Choice Process for 2 of 9 individuals. The following items were not found and/or not agency specific to the individual's current services: • **Secondary Freedom of Choice** ° Independent Living (#5) ° Adult Habilitation (#5) ° Community Access (#4) ° Speech Therapy (#5) ° Non-Medical Transportation (#5)		

Tag # 4C12 (CoP) - Monitoring & Evaluation of Services	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS** **J. Case Manager Monitoring and Evaluation of Service Delivery** (1) The Case Manager shall use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual as specified in the ISP. (2) Monitoring and evaluation activities shall include, but not be limited to: (a) Face-To-Face Contact: A minimum of twelve (12) face-to-face contact visits annually (1 per month) is required to occur between the Case Manager and the individual served as described in the ISP; an exception is that children may receive a minimum of four visits per year; (b) Jackson Class members require two (2) face-to–face contacts per month, one of which occurs at a location in which the individual spends the majority of the day (i.e., place of employment, habilitation program) and one at the person's residence; (c) For non-Jackson Class members who receive Community Living Services, at least every other month, one of the face-to-face visits shall occur in the individual's residence; (d) For adults who are not Jackson Class members and who do not receive Community Living Services, at least one face-to-face visit per quarter shall be in his or her home;	Based on record review, the Agency failed to use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual for 7 of 9 individuals. **Record review of Agency files found no evidence of Case Manager Monthly Case Notes for the following:** • Individual #1 - None found for 9/2009, 11/2009, 12/2009, 1/2010, 3/2010, 4/2010 & 6/2010 • Individual #3 - None found for 4/2010 & 6/2010 • Individual #4 - None found for 4/2010 • Individual #5 - None found for 10/2009, 11/2009, 12/2009, 1/2010, 3/2010, 4/2010 & 6/2010 • Individual #7 - None found for 11/2009 & 4/2010 **Record review of Agency files found no evidence indicating face-to-face visits were completed as required for the following individuals:** ° Individual #1 – No Face to Face Visit Summary Forms found for 8/2009 through 6/2010. ° Individual #2 – No Face to Face Visit Summary Forms found for 7/2009 through 2/2010. ° Individual #4 – No Face to Face Visit Summary Forms found for 7/2009. ° Individual #5 – No Face to Face Visit Summary Forms found for 7/2009 through 6/2010.		

(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. (f) Service monitoring for children: When a parent chooses fewer than twelve (12) annual units of case management, the Case Manager will inform the parent of the parent's responsibility for the monitoring and evaluation activities during the months he or she does not receive case management services, (g) It is appropriate to conduct face-to-face visits with the individual both during the time the individual is receiving a service and during times the individual is not receiving a service. The preferences of the individual shall be taken into consideration when scheduling a visit. Visits may be scheduled in advance or be unannounced visits depending on the nature of the need in monitoring service delivery for the individual.	° Individual #7 – No Face to Face Visit Summary Forms found for 7/2009 through 3/2010. **Record review of Agency files found face-to-face visits were not being completed as required by standard (2 b, c & d) for the following individuals:** Individual #9 (Jackson) • One site visit was noted between 7/2009 - 2/2010. ° 7/21/2009 – 7:35 pm – home ° 8/20/2009 – 4:20 pm – home ° 9/15/2009 – 4/50 pm – home ° 10/27/2009 – 8:20 pm – home ° 11/17/2009 – 4:50 pm – home ° 11/20/2009 – 4:15 pm – home ° 12/10/2009 – 5:10 pm – home ° 1/30/2010 – 4:00 pm – home ° 2/3/2010 – 12:25 pm – site		

(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.			

Tag # 4C15 - QA Requirements - Bi-Annual Reports & Provider Quarterly Reports	Scope and Severity Rating: B		
CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS **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: (1) Case Management Provider Agencies are to: (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. (b) Assure that reports and ISPs meet required timelines and include required content. (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. (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. (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. (d) Assure at least quarterly that Crisis Prevention/Intervention Plans are in place in	Based on record review, the Agency failed to ensure that reports and ISP's meet required timelines and include the required contents for 6 of 9 individuals. The following quarterly/bi-annual reports were not found: • **Family Living Quarterly Reports:** ° Individual #2 – None found for 7/2009 – 12/2009. ° Individual #4 – None found for 1/2010 – 3/2010. • **Supported Living Annual Assessment:** ° Individual #8 – None found for 7/2009 – 6/2010. • **Community Inclusion - Community Access Quarterly Reports:** ° Individual #4 – None found for 1/2010 – 3/2010. • **Community Inclusion - Supported Employment Quarterly Reports:** ° Individual #4 – None found for 1/2010 – 3/2010. • **Behavior Consultation Quarterly Reports:** ° Individual #2 – None found for 7/2009 – 3/2010. ° Individual #3 – None found for 1/2010 – 3/2010. ° Individual #7 – None found for 7/2009 – 6/2010. • **Speech & Language Pathology Bi-Annual**		

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. (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. (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. (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. (h) Maintain regular communication with all providers delivering services and products to the individual. (i) Establish and implement a written grievance procedure.	**Progress Reports:** ° Individual #2 – None found for 7/2009 – 6/2010. ° Individual #5 – None found for 7/2009 – 6/2010. ° Individual #7 – None found for 7/2009 – 6/2010. • **Nursing Quarterly Review:** ° Individual #2 (HAT score level 4) – None found for 7/2009 – 6/2010.		

(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. (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. (2) Case Managers and Case Management Provider Agencies are required to promote and comply with the Case Management Code of Ethics: (a) Case Managers shall provide the individual/guardian with a copy of the Code of Ethics when Addendum A is signed. (b) Complaints against a Case Manager for violation of the Code of Ethics brought to the attention of DDSD will be sent to the Case Manager's supervisor who is required to respond within 10 working days to DDSD with detailed actions taken. DDSD reserves the right to forward such complaints to the IRC.			

Tag # 4C21 - Case Mgt: Reimbursement	Scope and Severity Rating: B		
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** **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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4. V. CASE MANAGEMENT SERVICES REIMBURSEMENT - A. Billable Unit**	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 3 of 9 individuals. Individual #1 March 2010 • The Agency billed a total of 1 unit of Case Management on 3/8/2010. Documentation did not contain documentation of a face to face visit to justify billing. April 2010 • The Agency billed a total of 1 unit of Case Management on 4/5/2010. Documentation did not contain documentation of a face to face visit to justify billing. May 2010 • The Agency billed a total of 1 unit of Case Management on 5/10/2010. Documentation did not contain documentation of a face to face visit to justify billing. Individual #5 March 2010 • The Agency billed a total of 1 unit of Case Management on 3/8/2010. Documentation did not contain documentation of a face to face visit to justify billing. April 2010 • The Agency billed a total of 1 unit of Case Management on 4/5/2010. Documentation did not contain documentation of a face to face visit to justify billing. May 2010 • The Agency billed a total of 1 unit of Case Management on 5/10/2010. Documentation did not contain documentation of a face to face visit		

(1) Reimbursement to the Case Management Provider Agency is based upon a monthly rate for a maximum of 12 months per ISP year. (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. (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. (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. **B. Billable Services:** The following activities are deemed to be billable services: (1) All services and supports within the Case Management Scope of Services; and (2) Case Management may be provided at the same time on the same day as any other service.	to justify billing. Individual #7 March 2010 • The Agency billed a total of 1 unit of Case Management on 3/8/2010. Documentation did not contain documentation of a face to face visit to justify billing. April 2010 • The Agency billed a total of 1 unit of Case Management on 4/5/2010. Documentation did not contain documentation of a face to face visit to justify billing. May 2010 • The Agency billed a total of 1 unit of Case Management on 5/10/2010. Documentation did not contain documentation of a face to face visit to justify billing.		