Dear Ms. Velasquez and Ms. Schramm;

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.

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).

Plan of Correction:
The Plan of Correction 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.

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,

Erica Nilsen, BA

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

Survey Report #: Q.13.2.DDW.79006817.1&5.001.RTN.1.314
Survey Process Employed:

| Entrance Conference Date:                  | October 9, 2012 |
| Present:                                   |                |
| **A Step Above Case Management, Corporation** |                |
| Marie Velasquez, Co-Director               |                |
| Melinda Schramm, Co-Director               |                |
| **DOH/DHI/QMB**                            |                |
| Erica Nilsen, BA, Team Lead/Healthcare Surveyor |          |
| Jennifer Bruns, BSW, Healthcare Surveyor   |                |
| Marti Madrid, LBSW, Healthcare Surveyor    |                |

| Exit Conference Date:                     | October 12, 2012 |
| Present:                                  |                |
| **A Step Above Case Management, Corporation** |                |
| Marie Velasquez, Co-Director               |                |
| Melinda Schramm, Co-Director               |                |
| **DOH/DHI/QMB**                            |                |
| Erica Nilsen, BA, Team Lead/Healthcare Surveyor |          |
| Jennifer Bruns, BSW, Healthcare Surveyor   |                |
| Nicole Brown, MBA, Healthcare Surveyor     |                |
| Marti Madrid, LBSW, Healthcare Surveyor    |                |

Administrative Locations Visited: Number: 1

Total Sample Size: Number: 19
- 2 - Jackson Class Members
- 17 - Non-Jackson Class Members

Persons Served Records Reviewed: Number: 19

Case Managers Interviewed: Number: 5

Case Mgt Personnel Records Reviewed: Number: 5

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

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


Survey Report #: Q.13.2.DDW.79006817.1&5.001.RTN.1.314
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.”
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.
   - **Condition Level Tag**: Tag 4C04 Allocation Activities

**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 Level Tags**: Tag 4C07 ISP Development, Tag 4C08 ISP Development Process, Tag 4C10 Approval (completion) of the MAD 046/Budget, Tag 4C16 Requirements for reports and distribution of documents

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.
   - **Condition Level Tag**: Tag 4C12 Monitoring and Evaluation of Services

**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.
   - **Condition Level Tags**
     a. (General requirements for all providers)
       - Tag 1A20 DDSD Required Trainings (if <84% compliant)
       - Tag 1A22 Qualifications (Competency) for All Staff
       - Tag 1A25 Caregivers Criminal History Screening
       - Tag 1A26 COR Consolidated Online Registry Check (Employee Abuse Registry)
       - Tag 1A36 Qualifications for Service Coordinators
       - Tag 1A37 Individual Specific Trainings and Competency for Direct Service Personnel and Service Coordinators
       - Tag 4C17 Qualifications for Case Managers
       - Tag 6L06 Home Study Assessment. (Family Living only)
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.

**Condition level Tags:**
- Tag 1A32/6L14 Implementation of the ISP

**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 level Tags:**
- (Environmental) Individuals shall live and work in healthy and safe environments.
  - Tag 1A05 Health and Safety Related Policies and Procedures
  - Tag 1A16 Sanitation (Environmental Health and Safety)
  - Tag 6L25 Residential Requirement (Environmental Requirements)
- (Human Rights): Individuals shall be afforded their basic human rights.
  - Tag 1A31 Restriction of Rights

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.

**Condition level Tags:**
- Tag 6L13/1A08 Healthcare Maintenance, Monitoring and Follow-up
- Tag 1A09 Medication Delivery
- Tag 1A15 Healthcare Oversight
- Tag 1A15.2/5I09 Healthcare Documentation
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 in writing to the QMB Deputy Bureau Chief within 10 business days of receipt of the final Report of Findings.
2. The written request for an IRF must be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: http://dhi.health.state.nm.us/qmb
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRC process, email the IRF Chairperson, Scott Good at scott.good@state.nm.us for assistance.

The following limitations apply to the IRF process:

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

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

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

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

### Program
Developmental Disabilities Waiver

### Service
Case Management

### Monitoring Type
Routine Survey

### Date of Survey
October 9 - 12, 2012

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS Assurance – Plan of Care - ISP Development &amp; Monitoring</strong> – Service plans address all participates’ assessed needs (including health and safety risk factors) and goals, either by waiver services or through other means. Services plans are updated or revised at least annually or when warranted by changes in the waiver participants’ needs.</td>
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<tr>
<td><strong>Tag # 1A08 Agency Case File</strong></td>
<td><strong>Standard Level Deficiency</strong></td>
<td>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 18 of 19 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</td>
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<tr>
<td><strong>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</strong></td>
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<tr>
<td><strong>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</strong> 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.</td>
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<tr>
<td><strong>D. Provider Agency Case File for the Individual:</strong> 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:</td>
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<td>(1) Emergency contact information, including the</td>
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<tr>
<td>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 18 of 19 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</td>
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<tr>
<td><strong>Current Emergency &amp; Personal Identification Information</strong></td>
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<tr>
<td>◦ Did not contain Pharmacy Information (#6, 8 &amp; 9)</td>
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<tr>
<td>◦ Did not contain Physician Information (#8 &amp; 9)</td>
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<tr>
<td>◦ Did not contain Health Plan Information (#8)</td>
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<tr>
<td><strong>Annual ISP</strong></td>
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<tr>
<td>◦ Annual ISP Incomplete – No Actions Steps identified for the Work/Education/Volunteer Outcome (#9)</td>
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<tr>
<td>◦ Annual ISP Incomplete – Did not contain</td>
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<tr>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here: →</td>
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<tr>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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Survey Report #: Q.13.2.DDW.79006817.1&5.001.RTN.1.314
<table>
<thead>
<tr>
<th>Case Management Provider Information (13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>· Annual ISP Incomplete – Did not contain Supported Employment Provider Information (9 &amp; 13)</td>
</tr>
<tr>
<td>· Annual ISP Incomplete – Did not contain Adult Habilitation Provider Information (13)</td>
</tr>
<tr>
<td>· ISP Assessment Checklist Appendix 1 (#1, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15 &amp; 19)</td>
</tr>
<tr>
<td>· Addendum A (#10 &amp; 14)</td>
</tr>
</tbody>
</table>

**ISP Teaching & Support Strategies**

- **Individual #1 - TASS not found for:**
  - Develop Relationships/Fun Outcome:
    - “...will volunteer.”

- **Individual #6 - TASS not found for:**
  - Live Outcome:
    - “…will identify three grooming skills she will learn.”
    - “…will practice the grooming skills.”
  - Develop Relationships/Fun Outcome:
    - “…will look into Special Olympics.”
    - “…will practice bowling.”
    - “…will join a team.”

- **Individual #9 - TASS not found for:**
  - Live Outcome:
    - “…will learn to identify an emergency situation.”
    - “…will learn when to dial for emergency services when needed.”

- **Individual #10 - TASS not found for:**

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- 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;
- The individual’s complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);
- Progress notes and other service delivery documentation;
- Crisis Prevention/Intervention Plans, if there are any for the individual;
- 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;
- When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and
- Case records belong to the individual receiving services and copies shall be provided to the individual upon request.
- 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.
○ Work/Education/Volunteer Outcome:
  ➢ “…will apply for work with job coach.”
  ➢ “…will follow up by calling employers using a cheat sheet.”

○ Individual #11 - TASS not found for:
○ Live Outcome:
  ➢ “Write a shopping list.”
  ➢ “Shop for items two times a month.”
  ➢ “Purchase items two times a month.”

○ Work/Education/Volunteer Outcome:
  ➢ “…will independently turn on a computer.”
  ➢ “…will operate the mouse effectively.”
  ➢ “…will find the program he wants and open it.”
  ➢ “…will obtain additional software and accessories.”

○ Develop Relationships/Fun Outcome:
  ➢ “Get contact info.”
  ➢ “Make plan with peer to hang out.”
  ➢ “Get together with peer in the community.”

○ Individual #13 - TASS not found for:
○ Live Outcome:
  ➢ “…will research and schedule upcoming animal shows/activities that are coming up.”
  ➢ “…will participate in animal benefits or shows.”

○ Work/Education/Volunteer Outcome:
  ➢ “…will have a vocational profile.”

○ Individual #18 - TASS not found for:
○ Develop Relationships/Fun Outcome:
  ➢ “…will practice song with community access provider.”
- **Work/Education/Volunteer Outcome:**
  - “...will track pool games played.”

- **Health Outcome:**
  - “...will exercise at the gym.”
  - “...will prepare a healthy drink.”

- **Positive Behavioral Plan (#9 & 15)**
- **Positive Behavioral Crisis Plan (#2, 9, 10 & 15)**
- **Speech Therapy Plan (#10)**
- **Occupational Therapy Plan (#9)**
- **Physical Therapy Plan (#19)**
- **Health Assessment Tool (#6, 8, 9, 10 & 19)**
- **Health Care Plans**
  - **Aspiration**
    - Individual #6 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of a plan found.
  - **Weight/Body Mass Index**
    - Individual #12 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of a plan found.
    - Individual #14 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of a plan found.
  - **Constipation**
° Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.

° Individual #12 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.

- Incontinence
  ° Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.

- Oral Care
  ° Individual #15 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.

- Respiratory
  ° Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.

- Seizure
  ° Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.

- Skin/Wound
  ° Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.
- **Crisis Plans/Medical Emergency Response Plans**
  - Aspiration
    - Individual #6 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of a plan found.
    - Individual #12 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of a plan found.
  - Cardiac Condition
    - Individual #14 - As indicated by the IST section of ISP, the individual is required to have a plan. No evidence of a plan found.
  - Gastrointestinal (Reflux)
    - Individual #17 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of a plan found.
  - Hypertension
    - Individual #11 - As indicated by the IST section of ISP, the individual is required to have a plan. No evidence of a plan found.
  - Respiratory
    - Individual #12 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of a plan found.
  - Seizure
    - Individual #8 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of a plan found.
### Other Individual Specific Evaluations & Examinations:

- **Psychiatric Evaluation**
  - Individual #8 - Per documentation reviewed evaluation was completed on 6/21/2011. Follow-up was to be completed in 4 months. No documented evidence of the evaluation being completed was found.

- **Nutritional Evaluation**
  - Individual #11 - As indicated in the ISP Health & Safety section an evaluation is required. No documented evidence of the evaluation being completed was found.

- **Dental Exam**
  - Individual #4 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found.
  - Individual #8 - Individual #8 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found.
  - Individual #12 - As indicated by the documentation reviewed, exam was completed on 11/22/2011. Follow-up was to be completed in 6 months. No documented evidence of the follow-up being completed was found.
  - Individual #10 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found.
  - Individual #14 - As indicated by the DDSD
file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found.

- Individual #19 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found.

- **Auditory Exam**
  - Individual #10 - As indicated by the documentation reviewed, exam was completed on 5/4/2010. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found.
  - Individual #11 - As indicated by the documentation reviewed, exam was completed on 12/28/2010. Follow-up was to be completed in June 2011. No documented evidence of the follow-up being completed was found.

- **Vision Exam**
  - Individual #10 - As indicated by the documentation reviewed, exam was completed on 7/18/2007. Follow-up was to be completed in 12 months. No documented evidence of the follow-up being completed was found.
  - Individual #18 - As indicated by the documentation reviewed, exam was completed on 3/15/2010. Follow-up was to be completed in 12 months. No documented evidence of the follow-up being completed was found.

- **Pap Smear Exam**
  - Individual #3 - As indicated by the
documentation reviewed dated 1/21/2011, a referral was made to complete a Pap Smear. No documented evidence of the exam being completed was found.

° Individual #10 - As indicated by the documentation reviewed dated 12/5/2011, the exam was completed prior to annual physical. No documented evidence was found to verify visit was completed.

• Mammogram Exam
° Individual #3 - As indicated by the documentation reviewed dated 1/21/2011, a referral was made to complete a mammogram. No documented evidence of the exam being completed was found.

• Colonoscopy
° Individual #14 - As indicated by the documentation reviewed, exam was ordered 8/10/2011. No documented evidence was found to verify visit was completed.

• Cholesterol & Blood Glucose
° Individual #9 - As indicated by the documentation reviewed, lab work was ordered on 8/21/2012. No documented evidence was found to verify it was completed.

° Individual #14 - As indicated by the documentation reviewed, lab work was ordered on 8/10/2011. No documented evidence was found to verify it was completed.

• Blood Levels
° Individual #9 - As indicated by the documentation reviewed, lab work was ordered on 8/21/2012. No documented
Evidence found to verify it was completed.

- **Individual #14** - As indicated by the documentation reviewed, lab work was ordered on 8/10/2011. No documented evidence was found to verify it was completed.

- **Bladder Ultrasound**
  - **Individual #14** - As indicated by the documentation reviewed, the ultrasound was ordered on 8/10/2011. No documented evidence of the ultrasound being completed was found.

- **Renal Ultrasound**
  - **Individual #14** - As indicated by the documentation reviewed, the ultrasound was ordered on 8/10/2011. No documented evidence of the ultrasound being completed was found.

- **Lymphadenopathy Ultrasound**
  - **Individual #14** - As indicated by the documentation reviewed, the ultrasound was ordered on 8/10/2011. No documented evidence of the ultrasound being completed was found.

- **Liver Function Test**
  - **Individual #14** - As indicated by the documentation reviewed dated 7/19/2010, the test was ordered to be done every 6 months. No documented evidence of the test being completed was found.

- **Oncology Exam**
  - **Individual #14** - As indicated by the documentation reviewed, the exam was completed on 3/21/2012. The documented evidence of the exam was incomplete.
<table>
<thead>
<tr>
<th>Service</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ear, Nose, Throat Specialist</strong></td>
<td>#17</td>
</tr>
<tr>
<td>- As indicated by the documentation</td>
<td></td>
</tr>
<tr>
<td>reviewed dated 7/24/2012, a referral</td>
<td></td>
</tr>
<tr>
<td>was made to see an Ear, Nose &amp; Throat</td>
<td></td>
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<tr>
<td>Specialist. No documented evidence</td>
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<tr>
<td>of the visit being completed was</td>
<td></td>
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<tr>
<td>found.</td>
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<tr>
<td><strong>C-Spine X-Ray</strong></td>
<td>#18</td>
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<tr>
<td>- As indicated by the documentation</td>
<td></td>
</tr>
<tr>
<td>reviewed dated 12/13/2011, an x-ray</td>
<td></td>
</tr>
<tr>
<td>was ordered. No documented evidence</td>
<td></td>
</tr>
<tr>
<td>of the x-ray being completed was</td>
<td></td>
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<tr>
<td>found.</td>
<td></td>
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<tr>
<td><strong>Annual Physical Exam</strong></td>
<td>#19</td>
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<tr>
<td>- As indicated by the documentation</td>
<td></td>
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<tr>
<td>reviewed, the exam was completed</td>
<td></td>
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<tr>
<td>on 8/20/2012. Follow-up was to be</td>
<td></td>
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<tr>
<td>completed in 1 month. No documented</td>
<td></td>
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<tr>
<td>evidence of the follow-up being</td>
<td></td>
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<tr>
<td>completed was found.</td>
<td></td>
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<tr>
<td><strong>Orthopedic Exam</strong></td>
<td>#19</td>
</tr>
<tr>
<td>- As indicated by the documentation</td>
<td></td>
</tr>
<tr>
<td>reviewed dated 8/20/2012, a referral</td>
<td></td>
</tr>
<tr>
<td>was made to see Orthopedics at UNM</td>
<td></td>
</tr>
<tr>
<td>Hospital in September 2012 for an L</td>
<td></td>
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<tr>
<td>Ankle Abduction. No documented</td>
<td></td>
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<tr>
<td>evidence of the visit being</td>
<td></td>
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<tr>
<td>completed was found.</td>
<td></td>
</tr>
<tr>
<td><strong>Positive Behavior Support Assessment</strong></td>
<td>#15</td>
</tr>
<tr>
<td><strong>Speech/Language Therapy Evaluation</strong></td>
<td>#10</td>
</tr>
<tr>
<td><strong>Physical Therapy Evaluation</strong></td>
<td>#19</td>
</tr>
<tr>
<td>Tag #</td>
<td>Individual Service Planning</td>
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<tr>
<td>-------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>4C07</td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
</tr>
</tbody>
</table>

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.

The following was found with regards to ISP Outcomes:

- Individual #4:
  - Live Outcome: “Handle more daily living skills such as bathing with greater independence.” Outcome was does not indicate how and/or when it would be completed.
  - Work/Education/Volunteer Outcome: “Will attend Day Hab part time.” Outcome was does not indicate how and/or when it would be completed.

- Develop Relationships/Fun Outcome: “To be assisted in finding favorite places to go to in the community to socialize.” Outcome was does not indicate how and/or when it would be completed.

- Individual #14:
  - Develop Relationships/Fun Outcome: “Will create a scrapbook for her past, present and future activities”. Outcome was does not indicate how and/or when it would be completed.
  - Work/Education/Volunteer Outcome: “Will increase her stamina through scheduled exercise of her choice.” Outcome was

Provider:
State your Plan of Correction for the deficiencies cited in this tag here: →

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

}
<table>
<thead>
<tr>
<th>CONTENT OF INDIVIDUAL SERVICE PLANS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each ISP shall contain…</td>
</tr>
<tr>
<td>C. Outcomes:</td>
</tr>
<tr>
<td>(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.</td>
</tr>
<tr>
<td>(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.</td>
</tr>
<tr>
<td>does not indicate how and/or when it would be completed.</td>
</tr>
<tr>
<td>Tag # 4C08 ISP Development Process</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS - F. Case Manager ISP Development Process:</td>
</tr>
</tbody>
</table>
| (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. | - Rights & Responsibilities (#13 & 18)  
- Case Manager Code of Ethics (#4, 7, 13, 18 & 19) |
| (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 | |

Provider:  
State your Plan of Correction for the deficiencies cited in this tag here: →

Provider:  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
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:

(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.
<table>
<thead>
<tr>
<th>Tag # 4C09 Secondary FOC</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>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 10 of 19 individuals.</td>
<td>→</td>
</tr>
<tr>
<td><strong>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</strong></td>
<td><strong>G. Secondary Freedom of Choice Process</strong></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>(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.</td>
<td>The following items were not found and/or not agency specific to the individual's current services:</td>
<td></td>
</tr>
<tr>
<td>(2) The Case Manager will present the Secondary FOC form to the individual or authorized representative for selection of direct service providers.</td>
<td><strong>Secondary Freedom of Choice</strong></td>
<td></td>
</tr>
<tr>
<td>(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.</td>
<td>o Family Living (#7, 9 &amp; 18)</td>
<td></td>
</tr>
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<td></td>
<td>o Adult Habilitation (#5, 8 &amp; 12)</td>
<td></td>
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<td></td>
<td>o Community Access (#1, 4 &amp; 18)</td>
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<td></td>
<td>o Supported Employment (#10 &amp; 12)</td>
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<td></td>
<td>o Physical Therapy (#3 &amp; 8)</td>
<td></td>
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<tr>
<td></td>
<td>o Occupational Therapy (#4 &amp; 9)</td>
<td></td>
</tr>
<tr>
<td>Tag # 4C10  Apprv. MAD 046 &amp; Budget</td>
<td>Standard Level Deficiency</td>
<td></td>
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<tr>
<td><strong>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</strong></td>
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</tr>
<tr>
<td><strong>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</strong></td>
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</tr>
<tr>
<td>H. <strong>Case Management Approval of the MAD 046 Waiver Review Form and Budget</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Case Management Providers are authorized by DDSD to approve ISPs and budgets (including initial, annual renewals and revisions) for all individuals except as noted in section I of this chapter. This includes approval of support plans and strategies as incorporated in the ISP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) The Case Manager shall complete the MAD 046 Waiver Review Form and deliver it to all provider agencies within three (3) working days following the ISP meeting date. Providers will have the opportunity to submit corrections or objections within five (5) working days following receipt of the MAD 046. If no corrections or objections are received from the provider by the end of the fifth (5) working day, the MAD 046 may then be submitted as is to NMMUR. (Provider signatures are no longer required on the MAD 046.) If corrections/objections are received, these will be corrected or resolved with the provider(s) within the timeframe that allow compliance with number (3) below.</td>
<td></td>
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</tr>
<tr>
<td>(3) The Case Manager will submit the MAD 046 Waiver Review Form to NMMUR for review as appropriate, and/or for data entry at least thirty (30) calendar days prior to expiration of the previous ISP.</td>
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</tr>
<tr>
<td>(4) The Case Manager shall respond to NMMUR within specified timelines whenever a MAD 046 is returned for corrections or additional information.</td>
<td></td>
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</tr>
<tr>
<td>Based on record review the Agency failed to maintain documentation ensuring the Case Manager completed the MAD046 Waiver Review Form for 2 of 19 individuals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following item was not found:</td>
<td></td>
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<tr>
<td>• MAD 046 (#12 &amp; 17)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Provider:</strong></td>
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<tr>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
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<tr>
<td><strong>Provider:</strong></td>
<td></td>
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</tr>
<tr>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| }
<table>
<thead>
<tr>
<th>Tag # 4C12 Monitoring &amp; Evaluation of Services</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>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 2 of 19 individuals.</td>
<td>→</td>
</tr>
<tr>
<td><strong>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</strong></td>
<td><strong>Record review of Agency files found no evidence of Case Manager Monthly Case Notes for the following:</strong></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>J. Case Manager Monitoring and Evaluation of Service Delivery</td>
<td>(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.</td>
<td></td>
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<tr>
<td></td>
<td>(2) Monitoring and evaluation activities shall include, but not be limited to:</td>
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<td></td>
<td>(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;</td>
<td></td>
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<tr>
<td></td>
<td>(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;</td>
<td></td>
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<tr>
<td></td>
<td>(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;</td>
<td></td>
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<tr>
<td></td>
<td>(d) For adults who are not Jackson Class 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 2 of 19 individuals.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Record review of Agency files found no evidence indicating face-to-face visits were completed as required for the following individuals:</strong></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td></td>
<td>° Individual #6 – No Face to Face Visit Summary Forms found for 2/2012, 3/2012 &amp; 5/2012.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Record review of Agency files found face-to-face visits were not being completed as required by standard (2 b, c &amp; d) for the following individuals:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>° Individual #3 (Jackson Class Member)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>° No home visit was noted for 4/2012 4/23/2012 – Site Visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>° 4/30/2012 – Site Visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</table>
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;

(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.

(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 # 4C15.1 - QA Requirements - Bi-Annual Reports & Provider Quarterly Reports

#### 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

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to ensure that reports and ISP’s meet required timelines and include the required contents for 17 of 19 individuals.</td>
</tr>
</tbody>
</table>

The following quarterly/bi-annual reports were not found:

- **Supported Living Quarterly or Semi-Annual Reports:**
  - Individual #13 – None found for April 2012 – June 2012.
  - Individual #13 – None found for October 2010 – September 2011.

- **Family Living Quarterly or Semi-Annual Reports:**
  - Individual #6 – None found for September 2011 - February 2012.
  - Individual #7 – None found for June 2012 - August 2012.
  - Individual #11 – None found for September 2011 - May 2012.
  - Individual #14 – None found for June 2012 - August 2012.
  - Individual #18 – None found for February 2012 - July 2012.

- **Family Living Annual Assessment**
  - Individual #1 – None found for June 2011 - May 2012.

**Provider:**
State your Plan of Correction for the deficiencies cited in this tag here: →

**Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
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 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.

- Individual #4 – None found for February 2011 – January 2012.
- Individual #16 – None found for August 2011 – July 2012.

- Community Inclusion - Adult Habilitation Quarterly or Semi-Annual Reports:
  - Individual #3 – None found for May 2012 – July 2012.
  - Individual #5 – None found for October 2011 – December 2011 & June 2012 - August 2012.
  - Individual #7 – None found for May 2012 – July 2012.
  - Individual #8 – None found for September 2011 – August 2012.
  - Individual #12 – None found for September 2011 – January 2012.
  - Individual #13 – None found for October 2011 - August 2012.

- Community Inclusion - Community Access Quarterly or Semi-Annual Reports:
  - Individual #18 – None found for August 2011 – July 2012.
  - Individual #19 – None found for August 2011 - July 2012.

- Community Inclusion - Supported Employment Quarterly or Semi-Annual Reports:
  - Individual #7 – None found for May 2012 –
| (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. |
| (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

| (2) | Physical Bi-Annual Progress Reports: |
| | ◦ Individual #19 – None found for November 2011 - May 2012. |

| (2) | Speech & Language Pathology Bi-Annual Progress Reports: |
| | ◦ Individual #11 – None found for June 2011 - May 2012. |

| (2) | Behavior Consultation Quarterly Semi-Annual Reports: |
| | ◦ Individual #9 – None found for October 2011 – March 2012. |
| | ◦ Individual #10 – None found for July 2011 – July 2012. |
| | ◦ Individual #12 – None found for February 2012 – April 2012. |


Survey Report #: Q.13.2.DDW.79006817.185.001.RTN.1.314
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.

Nursing Quarterly or Semi-Annual Progress Reports:

- Individual #3 – None found for March 2012 - August 2012.
- Individual #18 – None found for August 2011 - October 2011 and February 2012 - July 2012.
### Standard of Care

**CMS Assurance – Level of Care** – *Initial and annual Level of Care (LOC) evaluations are completed within timeframes specified by the State.*

<table>
<thead>
<tr>
<th>Tag # 4C04 Assessment Activities</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| **Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007**  
**CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS**  

**B. Case Management Assessment Activities:** Assessment activities shall include but are not limited to the following requirements:  

1. Complete and compile the elements of the Long Term Care Assessment Abstract (LTCAA) packet to include:  
   
   a. LTCAA form (MAD 378);  
   b. Comprehensive Individual Assessment (CIA);  
   c. Current physical exam and medical/clinical history;  
   d. Norm-referenced adaptive behavioral assessment; and  
   e. A copy of the Allocation Letter (initial submission only).  

2. Prior to service delivery, obtain a copy of the Medical Assistant Worker (MAW) letter to verify that the county Income Support Division (ISD) office of the Human Services Department (HSD) has completed a determination that the individual meets financial and medical eligibility to participate.  

Based on record review, the Agency failed to complete and compile the elements of the Long Term Care Assessment Abstract (LTCAA) packet for 5 of 19 individuals.  

- Annual Physical (#7, 11, 12 & 16)  
- Client Individual Assessment (CIA) (#8)  

The following items were not found and/or incomplete:  

Provider:  
State your Plan of Correction for the deficiencies cited in this tag here: →

Provider:  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

Provider:  

| Provider: | | | | |
| Provider: | | | | |
in the DD Waiver program.

(3) Provide a copy of the MAW letter to service providers listed on the ISP budget (MAD 046).
**Standard of Care** | **Deficiencies** | **Agency Plan of Correction, On-going QA/QI & Responsible Party** | **Date Due**
---|---|---|---

**CMS Assurance – Qualified Providers** – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.

<table>
<thead>
<tr>
<th>Tag # 1A25 Caregiver Criminal History Screening</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:</td>
<td>Based on record review, the Agency failed to maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 1 of 5 Agency Personnel.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:</td>
<td>The following Agency Personnel Files contained Caregiver Criminal History Screenings, which were not specific to the Agency:</td>
<td></td>
</tr>
<tr>
<td>A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</td>
<td>• #43 – Date of hire 8/1/2005</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:</td>
<td></td>
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<tr>
<td>A. homicide;</td>
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<td>B. trafficking, or trafficking in controlled substances;</td>
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<td>C.</td>
<td>kidnapping, false imprisonment, aggravated assault or aggravated battery;</td>
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<tr>
<td>D.</td>
<td>rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;</td>
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<tr>
<td>E.</td>
<td>crimes involving adult abuse, neglect or financial exploitation;</td>
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<tr>
<td>F.</td>
<td>crimes involving child abuse or neglect;</td>
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<tr>
<td>G.</td>
<td>crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</td>
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<tr>
<td>H.</td>
<td>an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</td>
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</tbody>
</table>


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**Tag # 1A26  Consolidated On-line Registry / Employee Abuse Registry**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
</table>
| **NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:** Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.  
   A. **Provider requirement to inquire of registry.** A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.  
   B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.  
   D. **Documentation of inquiry to registry.** The provider shall maintain documentation in the employee’s personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on record review, that the Agency failed to maintain documentation in the employee’s personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 1 of 5 Agency Personnel.

The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:


**Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →**
the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual’s current licensure as a health care professional or current certification as a nurse aide.

F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.


Chapter 1.IV. General Provider Requirements. D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee’s qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as
required by the Department of Health, Division of Health Improvement.
<table>
<thead>
<tr>
<th>Tag #</th>
<th>Incident Management System - Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A28.1</td>
<td>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</td>
<td>Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 1 of 5 Agency Personnel.</td>
<td></td>
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</tbody>
</table>

- Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#40)

**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.

**Provider:**

State your Plan of Correction for the deficiencies cited in this tag here: →

**Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →


C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
<table>
<thead>
<tr>
<th>Tag # 4C17 Case Manager Qualifications - Required Training</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to ensure that Training requirements were met for 1 of 5 Case Managers.</td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</strong></td>
<td><strong>E. Case Manager Qualifications:</strong> Case Managers, whether subcontracting or employed by a Provider Agency, shall meet these requirements:</td>
<td></td>
</tr>
<tr>
<td>(1) Case Managers shall possess these qualifications: …</td>
<td>(2) Within specified timelines, Case Managers shall meet the requirements for training specified in the DDSD policy governing the training requirements for Case Managers serving individuals with developmental disabilities. All Case Management Provider Agencies are required to report required personnel training status to the DDSD Statewide Training Database as follows:</td>
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</tr>
<tr>
<td>(a) Initial comprehensive personnel status report (name, date of hire, identification number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; and</td>
<td>(b) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, or agency position changes, and name changes.</td>
<td></td>
</tr>
<tr>
<td><strong>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title:</strong> Training Requirements for Case Management Agency</td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
</tbody>
</table>

**Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
II. POLICY STATEMENTS:
A. Individuals shall receive services from competent and qualified case managers.

B. Case management staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.

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

D. In addition to the applicable requirements described in policy statements B – C (above), case managers and case management supervisors shall complete DDSD-approved core curriculum training...

E. Substitutes shall comply with the training requirements of the staff for whom they are substituting.

F. To complete a core curriculum-training course, trainees shall achieve 100% competency rating during the competency verification process.
<table>
<thead>
<tr>
<th>Tag #</th>
<th>Supervision Req.</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>4C20</td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</td>
<td>Based on record review, the agency failed to implement written procedures for training, supervision and corrective action for Case Management staff and/or Subcontractors.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>H.</td>
<td>Case Management Provider Agency Supervision Requirements</td>
<td>During the on-site week of October 9, 2012 a copy of the agency's policy and procedure regarding case management training, supervision and correction action for Case Management staff and/or subcontractors was requested. The information provided by the Agency of the Agency's policy and procedures did not contain:</td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td>Provider Agencies shall implement written procedures for training, supervision and corrective action for Case Management staff and/or subcontractors. Documentation of above needs to be maintained in personnel files.</td>
<td>- Corrective Action for Case Management staff and/or Subcontractors</td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>Individuals providing supervision/oversight must have at least two (2) years as experienced Case Managers for individuals with developmental disabilities and must meet all qualifications for Case Managers under Section IV, E, (1). Case management supervisors who also carry a caseload may not perform quality assurance reviews on their own work.</td>
<td></td>
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<tr>
<td>(3)</td>
<td>Contract performance management procedures equivalent to employee supervision procedures shall be carried out for Case Management sub-contractors.</td>
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<tr>
<td>(4)</td>
<td>Provider Agencies shall monitor and oversee the eligibility process for new allocations and for re-determinations.</td>
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</tr>
<tr>
<td>(5)</td>
<td>On a quarterly basis, Provider Agencies are required to mentor and monitor service planning and ISP development by Case Managers, including a quality assurance review of a sample of ISPs written by each Case Manager.</td>
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</tbody>
</table>


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members, all ISPs are required to be reviewed; for non-Jackson Class members, a ten percent (10%) sample is required. Copies of all critiqued ISPs, both Jackson and non-Jackson samples, shall be submitted to the respective DDSD Regional Office.

(6) Provider Agencies are required to evaluate the quality of monitoring conducted by Case Managers with regard to ISP implementation and health and safety for individuals served, including timely medical intervention to follow-up on recommendations by medical and/or clinical practitioners.

(7) Provider Agencies shall oversee Quality Assurance and Improvement Requirements for Case Managers.

(8) Provider Agencies shall assure Case Manager compliance with training requirements.

(9) Provider Agencies are required to assure all records include current provider quarterly reports and that each record is complete in adherence with DDSD policies, procedures and standards.

(10) Provider Agencies must assure adherence to timelines set forth by DDSD.
### CMS Assurance – Health and Welfare – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.

<table>
<thead>
<tr>
<th>Tag #</th>
<th>CQI System</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A03</td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to update and implement their Continuous Quality Management System on an annual basis.</td>
</tr>
<tr>
<td></td>
<td>CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS</td>
<td>Review of the Agency's Continuous Quality Improvement Plan provided during the on-site survey did not contain the components required by Standards.</td>
</tr>
<tr>
<td></td>
<td>I. Continuous Quality Management System: Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider’s service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to:</td>
<td>The Agency’s CQI Plan did not contain the following components:</td>
</tr>
<tr>
<td></td>
<td>(1) Individual access to needed services and supports;</td>
<td>- Individual access to needed services and supports;</td>
</tr>
<tr>
<td></td>
<td>(2) Effectiveness and timeliness of implementation of Individualized Service Plans;</td>
<td>- Effectiveness and timeliness of implementation of Individualized Service Plans;</td>
</tr>
<tr>
<td></td>
<td>(3) Trends in achievement of individual outcomes in the Individual Service Plans;</td>
<td>- Quality and completeness documentation;</td>
</tr>
<tr>
<td></td>
<td>(4) Trends in medication and medical incidents leading to adverse health events;</td>
<td>- Trends in individual and guardian satisfaction;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- A monitoring protocol that provides for the evaluation of quality, effectiveness and continued need for services and supports provided to the individual;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assure that reports and ISPs meet required timelines and include required content;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Annual satisfaction surveys with individuals</td>
</tr>
</tbody>
</table>

Provider:
State your Plan of Correction for the deficiencies cited in this tag here: →

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; and

(6) Quality and completeness documentation; and

(7) Trends in individual and guardian satisfaction.


**DDSD DDW Std. Chapter 4.IV.C.1 Continuous Quality Management System:**

Agency shall have an Internal Quality Assurance and Improvement Plan with annual updates. At a minimum does the Agency’s Internal Quality Assurance & Improvement Plan address the following:

- A monitoring protocol that provides for the evaluation of quality, effectiveness and continued need for services and supports provided to the individual.

- Assure that reports and ISPs meet required timelines and include required content.

- Annual satisfaction surveys with individuals regarding case management services.

- How the Agency will maintain regular communication with all providers delivering services and products to the individual.

**7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:**

**E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system regarding case management services; and

- How the Agency will maintain regular communication with all providers delivering services and products to the individual.
shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:

(1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;

(2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;

(4) community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.
<table>
<thead>
<tr>
<th>Tag # 1A05 General Requirements</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to review and update its written policies and procedures every three years or as needed.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>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.</td>
<td>The following policies and procedures provided during the on-site survey (October 9 - 12, 2012) showed no evidence of being reviewed every three years or being updated as needed:</td>
<td></td>
</tr>
<tr>
<td>(2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.</td>
<td>- “On-Call Policy and Procedure” - Last reviewed and/or revised 7/15/2009.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- “Incident Management System” – policy not dated.</td>
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</tr>
<tr>
<td></td>
<td>- “Grievance Policy” – policy not dated.</td>
<td></td>
</tr>
</tbody>
</table>

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
<table>
<thead>
<tr>
<th>Tag #</th>
<th>Incident Mgt. System - Parent/Guardian Training</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A28.2</td>
<td>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 require all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</td>
<td>Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers’ Property, for 5 of 19 individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>E. Consumer and Guardian Orientation Packet: Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer’s file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.</td>
<td></td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</table>
### Tag # 1A29  Complaints / Grievances - Acknowledgement

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 19 individuals.</td>
</tr>
<tr>
<td>• Grievance/Complaint Procedure Acknowledgement (13 &amp; 18)</td>
</tr>
</tbody>
</table>

**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

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**Provider:**  
State your Plan of Correction for the deficiencies cited in this tag here: →

**Provider:**  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
<table>
<thead>
<tr>
<th>Tag #</th>
<th>Client Rights/Human Rights</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
</table>
| 1A31  | **RESTRICTIONS OR LIMITATION OF CLIENT’S RIGHTS:**  
A. A service provider shall not restrict or limit a client's rights except:  
(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or  
(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or  
(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].  
B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider’s behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.  
C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]  
**Long Term Services Division**  
**Policy Title:** Human Rights Committee  
**Requirements Eff Date:** March 1, 2003  
**IV. POLICY STATEMENT** - Human Rights | Based on record review, the Agency failed to ensure the rights of Individuals was not restricted or limited for 1 of 19 Individuals.  
A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions.  
No documentation was found regarding Human Rights Approval was ensured for the following:  
- Physical Restraint (MANDT) (Individual #2)  
- Psychotropic Medications to control behaviors. No evidence found of Human Rights Committee approval. (Individual #2)  
- Removal of Clothing. No evidence found of Human Rights Committee approval. (Individual #2)  
- Restriction of telephone. No evidence found of Human Rights Committee approval. (Individual #2)  
- Line of sight. No evidence found of Human Rights Committee approval. (Individual #2) | State your Plan of Correction for the deficiencies cited in this tag here: → |
|       | **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → | }
Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:
- Aversive Intervention Prohibitions
- Psychotropic Medications Use
- Behavioral Support Service Provision.

A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS
Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval.

2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual’s Individual Service Plan.
Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006

B. 1. e. If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).
<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS Assurance – Financial Accountability</strong> – <em>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</em></td>
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</tbody>
</table>

**TAG #1A12 All Services Reimbursement (No Deficiencies)**

**Chapter 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION**

**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.

Billing for Case Management services was reviewed for 19 of 20 individuals. *Progress notes and billing records supported billing activities for the months of June, July and August 2012.*
Date: July 09, 2013
To: Marie Velasquez, Co-Director
Melinda Schramm, Co-Director
Provider: A Step Above Case Management
Address: 3150 Carlisle Blvd NE Ste. 25
State/Zip: Albuquerque, NM  87110
E-mail Address: jelliebeans@msn.com
Region: Metro & Northwest
Survey Date: October 9 - 12, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Case Management
Survey Type: Routine
Team Leader: Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Velasquez and Ms. Schramm;

You have completed all the requirements per the Internal Review Committee (IRC).

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

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

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

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

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

Sincerely,

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

Q.14.1.DDW.79006817.1&5.001.RTN.09.090