



Date: May 25, 2012

To: Scott Newland, President
Provider: Unidas Case Management Inc.
Address: 2403 San Mateo Blvd., NE W-17
State/Zip: Albuquerque, NM 87110

E-mail Address: rscottnewland@gmail.com

CC: Kristin Pasquini-Johnson, QA Director
Address: 2403 San Mateo Blvd., NE W-17
State/Zip: Albuquerque, NM 87110

Region: Metro & Northeast
Survey Date: April 30 - May 3, 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
Team Members: Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Maurice Gonzales, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Marti Madrid, LBSW, Division of Health Improvement/Quality Management Bureau, Tony Fragua, BFA, Division of Health Improvement/Quality Management Bureau & Cynthia Nielsen, MSN, RN, Division of Health Improvement/Quality Management Bureau.

Dear Mr. Newland,

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.



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

QMB Report of Findings – Unidas Case Management, Inc. –Metro & Northeast Regions – April 30 - May 3, 2012

Survey Report #: Q.12.4.DDW.D3434.(2 & 5).001.RTN.01. 146

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).

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 505-699-0714 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 Process Employed:

Entrance Conference Date: April 30, 2012

Present: **Unidas Case Management, Inc.**
Scott Newland, President
Linda Piasecki, HR Director

DOH/DHI/QMB

Erica Nilsen, BA, Team Lead/Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Maurice Gonzales, BS, Healthcare Surveyor
Marti Madrid, LBSW, Healthcare Surveyor

Exit Conference Date: May 3, 2012

Present: **Unidas Case Management, Inc.**
Scott Newland, President
Kristin Pasquini-Johnson, QA Director
Eric Hankla, Finance Director

DOH/DHI/QMB

Erica Nilsen, BA, Team Lead/Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Maurice Gonzales, BS, Healthcare Surveyor
Tony Fragua, BFA, Healthcare Surveyor

Administrative Locations Visited Number: 1

Total Sample Size Number: 43
5 - Jackson Class Members
38 - Non-Jackson Class Members

Persons Served Records Reviewed Number: 43

Case Managers Interviewed Number: 21

Case Mgt Personnel Records Reviewed Number: 22

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

QMB Report of Findings – Unidas Case Management, Inc. –Metro & Northeast Regions – April 30 - May 3, 2012

Survey Report #: Q.12.4.DDW.D3434.(2 & 5).001.RTN.01. 146

Attachment A

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

Introduction:

After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued non compliance.

Agencies must submit their Plan of Correction within 10 business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days will be referred to the Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings. (Providers who fail to complete a POC within the 45 business days allowed shall be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-699-0714 or email at scott.good@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 Deputy Chief, Scott Good at 505-699-0714 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to Scott Good, QMB Deputy Chief in any of the following ways:
 - a. Electronically at scott.good@state.nm.us (*preferred method*)
 - b. Fax to 505-222-8661, or
 - c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approve” or “denied.”

- a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
 - b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
 - c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
 - d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. You may submit your documents by postal mail (paper hard copy or on a disc), fax, or electronically (scanned and attached to e-mails).
3. All submitted documents must be annotated; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. For billing deficiencies, you must submit:
 - a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
 - b. Copies of “void and adjust” forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Deputy Chief at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

QMB Determinations of Compliance

- “Compliance with Conditions of Participation”
The QMB determination of “Compliance with Conditions of Participation,” indicates that a provider is in compliance with all ‘Conditions of Participation,’ (CoP) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals’ health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with *all* Conditions of Participation.
- “Partial-Compliance with Conditions of Participation”
The QMB determination of “Partial-Compliance with Conditions of Participation” indicates that a provider is out of compliance with one (1) to three (3) ‘Conditions of Participation.’ This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety. The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

Providers receiving a repeat determination of ‘Partial-Compliance’ for repeat deficiencies of CoPs may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- “Non-Compliant with Conditions of Participation”:
The QMB determination of “Non-Compliance with Conditions of Participation,” indicates a provider is significantly out of compliance with Conditions of Participation and/or has:
 - Four (4) Conditions of Participation out of compliance.
 - Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
 - Any finding of actual harm or Immediate Jeopardy.The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

Providers receiving a repeat determination of ‘Non-Compliance’ will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

Attachment C

Guidelines for the Provider Informal Reconsideration of Finding (IRF) Process

Introduction:

Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated “Document Request,” or “administrative Needs,” etc. forms. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: <http://dhi.health.state.nm.us/qmb>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRC process, email the IRF Chairperson, Scott Good at scott.good@state.nm.us for assistance.

The following limitations apply to the IRF process:

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

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

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

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

Agency: Unidas Case Management Inc. – Metro & Northeast Regions
Program: Developmental Disabilities Waiver
Service: Case Management
Monitoring Type: Routine Survey
Date of Survey: April 30 - May 3, 2012

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>CMS Assurance – Plan of Care - ISP Development & Monitoring – Service plans address all participates’ assessed needs(including health and safety risk factors) and goals, either by waiver services or through other means. Services plans are updated or revised at least annually or when warranted by changes in the waiver participants’ needs.</p>			
<p>Tag # 1A08 Agency Case File</p>	<p>Standard Level Deficiency</p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual’s case file shall include the following</p>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 11 of 43 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Speech Therapy Plan (#8 &13) • Occupational Therapy Plan (#1 & 40) • Physical Therapy Plan (#27) • Special Health Care Needs: <ul style="list-style-type: none"> • Nutritional/Dietary Plan <ul style="list-style-type: none"> ◦ Individual #31 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • Nutritional Evaluation <ul style="list-style-type: none"> ◦ Individual #10- Per documentation reviewed evaluation was completed on 	<p>Provider: State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>requirements:</p> <ol style="list-style-type: none"> (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: <ol style="list-style-type: none"> (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge 	<p>9/6/2011. Follow-up was to be completed in 6 months. No documented evidence of the evaluation being completed was found.</p> <ul style="list-style-type: none"> ◦ Individual #23 - As indicated by the ISP, the individual is required to have an evaluation. No documented evidence of the evaluation being completed was found. <p>• Dental Exam</p> <ul style="list-style-type: none"> ◦ Individual #32 - As indicated by the documentation reviewed, exam was completed on 5/26/2011. Follow-up was to be completed in 6 months. No documented evidence of the follow-up being completed was found. <p>• Auditory Exam</p> <ul style="list-style-type: none"> ◦ Individual #27 - As indicated by the documentation reviewed, exam was completed on 2/8/2010. Per the primary doctor's orders written on 4/21/2011, an auditory exam is to be completed every 2 years. No documented evidence of the exam being since 2/2010 completed was found. ◦ Individual #31 - As indicated by the documentation reviewed, exam was completed on 4/20/09. Per doctor's orders an auditory exam and hearing aide check is to be completed annually. No documented evidence of the follow-up being completed was found. <p>• Vision Exam</p> <ul style="list-style-type: none"> ◦ Individual #7 - As indicated by the documentation reviewed, exam was completed on 7/6/2009. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed 		
--	--	--	--

<p>from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>	<p>was found.</p> <ul style="list-style-type: none"> • Bone Density Exam <ul style="list-style-type: none"> ◦ Individual #37 - As indicated by the documentation reviewed, exam was completed on 5/28/2008. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. • Speech/Language Therapy Evaluation (#8 & 31) • Physical Therapy Evaluation (#8) 		
---	---	--	--

Tag # 1A41 Required IDT Meetings	Standard Level Deficiency		
<p>NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS:</p> <p>H. The IDT shall be convened to discuss and modify the ISP, as needed, to address:</p> <ul style="list-style-type: none"> (1) a significant life change, including a change in medical condition or medication that affects the individual's behavior or emotional state; (2) situations where an individual is at risk of significant harm. In this case the team shall convene within one working day, in person or by teleconference; if necessary, the ISP shall be modified accordingly within seventy-two (72) hours; (3) changes in any desired outcomes, (e.g. desired outcome is not met, a change in vocational goals or the loss of a job); (4) the loss or death of a significant person to the individual; (5) a serious accident, illness, injury or hospitalization that disrupts implementation of the ISP; (6) individual, guardian or provider requests for a program change or relocation, or when a termination of a service is proposed; the DDS's policy no. 150 requires the IDT to meet and develop a transition plan whenever an individual is at risk of discharge by the provider agency or anticipates a change of provider agency to identify strategies and resources needed; if the individual or guardian is requesting a discharge or a change of provider agency, or there is an impending change in housemates the team must meet to develop a transition plan; (7) situations where it has been determined 	<p>Based on record review, the Agency failed to convene the IDT to discuss and/or modify the ISP and/or address significant changes as required by regulation for 1 of 43 individuals.</p> <p>Review of documentation found the following IDT Meeting did not convene as required:</p> <ul style="list-style-type: none"> • Individual #27 <ul style="list-style-type: none"> ◦ As indicated by the documentation reviewed, the individual was hospitalized in 2/2012 and 3/2012. No documented evidence of IDT meetings taking place were found. 	<p>Provider: State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>the individual is a victim of abuse, neglect or exploitation;</p> <p>(8) criminal justice involvement on the part of the individual (e.g., arrest, incarceration, release, probation, parole);</p> <p>(9) any member of the IDT may also request that the team be convened by contacting the case manager; the case manager shall convene the team within ten (10) days of receipt of any reasonable request to convene the team, either in person or through teleconference;</p> <p>(10) for any other reason that is in the best interest of the individual, or any other reason deemed appropriate, including development, integration or provision of services that are inconsistent or in conflict with the desired outcomes of the ISP and the long term vision of the individual;</p> <p>(11) whenever the DDS decides not to approve implementation of an ISP because of cost or because the DDS believes the ISP fails to satisfy constitutional, regulatory or statutory requirements.</p>			
---	--	--	--

Tag # 4C09 Secondary FOC	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS G. Secondary Freedom of Choice Process</p> <p>(1) The Case Management Provider Agency will ensure that it maintains a current Secondary Freedom of Choice (FOC) form that includes all service providers offering services in that region.</p> <p>(2) The Case Manager will present the Secondary FOC form to the individual or authorized representative for selection of direct service providers.</p> <p>(3) At least annually, at the time rights and responsibilities are reviewed, individuals and guardians served will be reminded that they may change providers at any time, as well as change types of services. At this time, Case Managers shall offer to review the current Secondary FOC list with individuals and guardians served. If they are interested in changing, a new FOC shall be completed.</p>	<p>Based on record review, the Agency failed to maintain current Secondary Freedom of Choice documentation and ensure individuals obtained all services through the Freedom of Choice Process for 1 of 43 individuals.</p> <p>The following items were not found and/or not agency specific to the individual's current services :</p> <ul style="list-style-type: none"> • Secondary Freedom of Choice <ul style="list-style-type: none"> ◦ Behavior Consultation (#27) ◦ Speech Therapy (#27) ◦ Occupational Therapy (#27) 	<p>Provider: State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

Tag # 4C12 Monitoring & Evaluation of Services	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</p> <p>J. Case Manager Monitoring and Evaluation of Service Delivery</p> <p>(1) The Case Manager shall use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual as specified in the ISP.</p> <p>(2) Monitoring and evaluation activities shall include, but not be limited to:</p> <p>(a) Face-To-Face Contact: A minimum of twelve (12) face-to-face contact visits annually (1 per month) is required to occur between the Case Manager and the individual served as described in the ISP; an exception is that children may receive a minimum of four visits per year;</p> <p>(b) Jackson Class members require two (2) face-to-face contacts per month, one of which occurs at a location in which the individual spends the majority of the day (i.e., place of employment, habilitation program) and one at the person's residence;</p> <p>(c) For non-Jackson Class members who receive Community Living Services, at least every other month, one of the face-to-face visits shall occur in the individual's residence;</p> <p>(d) For adults who are not Jackson Class</p>	<p>Based on record review, the Agency failed to use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual for 4 of 43 individuals.</p> <p>Record review of Agency files found face-to-face visits were NOT being completed as required by standard (2 b, c & d) for the following individuals:</p> <p>Individual #1 (Non-Jackson)</p> <ul style="list-style-type: none"> • One out of home site visit was noted between 4/2011 & 3/2012. <ul style="list-style-type: none"> ◦ 4/12/2011 - Home Visit ◦ 5/5/2011 - Home Visit ◦ 6/2/2011 - Home Visit ◦ 7/12/2011 - Home Visit ◦ 8/9/2011 - Home Visit ◦ 9/6/2011 - Home Visit ◦ 10/4/2011 - Site Visit (ISP Meeting) ◦ 11/15/2011 - Home Visit ◦ 12/7/2011 - Home Visit ◦ 1/12/2012 - Home Visit ◦ 2/1/2012 - Home Visit ◦ 3/7/2012 - Home Visit <p>Individual #4 (Non-Jackson)</p> <ul style="list-style-type: none"> • One out of home site visit was noted between 4/2011 & 3/2012. <ul style="list-style-type: none"> ◦ 4/19/2011 - Home Visit ◦ 5/26/2011 - Home Visit ◦ 6/16/2011 - Site Visit (ISP Meeting) ◦ 7/19/2011 - Home Visit 	<p>Provider: State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>members and who do not receive Community Living Services, at least one face-to-face visit per quarter shall be in his or her home;</p> <p>(e) If concerns regarding the health or safety of the individual are documented during monitoring or assessment activities, the Case Manager shall immediately notify appropriate supervisory personnel within the Provider Agency and document the concern. If the reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office and/or the Division of Health Improvement (DHI) as appropriate to the nature of the concern. Unless the nature of the concern is urgent, no more than fifteen (15) working days shall be allowed for remediation or development of an acceptable plan of remediation. This does not preclude the Case Managers' obligation to report abuse, neglect or exploitation as required by New Mexico Statute.</p> <p>(f) Service monitoring for children: When a parent chooses fewer than twelve (12) annual units of case management, the Case Manager will inform the parent of the parent's responsibility for the monitoring and evaluation activities during the months he or she does not receive case management services,</p> <p>(g) It is appropriate to conduct face-to-face visits with the individual both during the time the individual is receiving a service and during times the individual is not</p>	<ul style="list-style-type: none"> ◦ 8/23/2011 - Home Visit ◦ 9/21/2011 - Home Visit ◦ 10/25/2011 - Home Visit ◦ 11/22/2011 - Home Visit ◦ 12/13/2011 - Home Visit ◦ 1/23/2012 - Home Visit ◦ 2/13/2012 - Home Visit ◦ 3/12/2012 - Home Visit <p>Individual #24 (Non-Jackson)</p> <ul style="list-style-type: none"> • One out of home visit was noted between 4/2011 & 3/2012. <ul style="list-style-type: none"> ◦ 4/28/2011 - Home Visit ◦ 5/24/2011 - Home Visit ◦ 6/28/2011 - Home Visit ◦ 7/25/2011 - Site Visit ◦ 8/31/2011 - Home Visit ◦ 9/26/2011 - Home Visit ◦ 10/27/2011 - Home Visit ◦ 11/29/2011 - Home Visit ◦ 12/23/2011 - Home Visit ◦ 1/30/2012 - Home Visit ◦ 2/28/2012 - Home Visit ◦ 3/26/2012 - Home Visit <p>Individual #32 (Non-Jackson)</p> <ul style="list-style-type: none"> • One out of home site visit was noted between 4/2011 & 3/2012. <ul style="list-style-type: none"> ◦ 4/19/2011 - Home Visit ◦ 5/5/2011 - Home Visit ◦ 6/21/2011 - Home Visit ◦ 7/25/2011 - Home Visit ◦ 8/16/2011 - Home Visit ◦ 9/15/2011 - Home Visit ◦ 10/11/2011 - Home Visit 		
---	---	--	--

<p>receiving a service. The preferences of the individual shall be taken into consideration when scheduling a visit. Visits may be scheduled in advance or be unannounced visits depending on the nature of the need in monitoring service delivery for the individual.</p> <p>(h) Communication with IDT members: Case Managers shall facilitate and maintain communication with the individual or his or her representative, other IDT members, providers and other relevant parties to ensure the individual receives maximum benefit of his or her services. Case Managers need to ensure that any needed adjustments to the service plan are made, where indicated. Concerns identified through communication with teams that are not remedied within a reasonable period of time shall be reported in writing to the respective regional office and/or the Division of Health Improvements, as appropriate to the concerns.</p>	<ul style="list-style-type: none"> ◦ 11/3/2011 - Home Visit ◦ 12/6/2011 - Home Visit ◦ 1/10/2012 - Home Visit ◦ 2/10/2012 - Home Visit ◦ 3/27/2012 - Site Visit (ISP Meeting) 		
---	--	--	--

Tag # 4C15.1 - QA Requirements - Bi-Annual Reports & Provider Quarterly Reports	Standard Level Deficiency		
<p>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</p> <p>C. Quality Assurance Requirements: Case Management Provider Agencies will use an Internal Quality Assurance and Improvement Plan that must be submitted to and reviewed by the Statewide Case Management Coordinator, that shall include but is not limited to the following:</p> <p>(1) Case Management Provider Agencies are to:</p> <p>(a) Use a formal ongoing monitoring protocol that provides for the evaluation of quality, effectiveness and continued need for services and supports provided to the individual. This protocol shall be written and its implementation documented.</p> <p>(b) Assure that reports and ISPs meet required timelines and include required content.</p> <p>(c) Conduct a quarterly review of progress reports from service providers to verify that the individual's desired outcomes and action plans remain appropriate and realistic.</p> <p>(i) If the service providers' quarterly reports are not received by the Case Management Provider Agency within fourteen (14) days following the end of the quarter, the Case Management Provider Agency is to contact the service provider in writing requesting the report within one week from that date.</p> <p>(ii) If the quarterly report is not received</p>	<p>Based on record review, the Agency failed to ensure that reports and ISP's meet required timelines and include the required contents for 4 of 43 individuals.</p> <p>The following quarterly/bi-annual reports were not found:</p> <ul style="list-style-type: none"> • Community Inclusion - Adult Habilitation Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #1 – None found for July 2011 - September 2011. ◦ Individual #40 – None found for April 2011 - June 2011. • Speech & Language Pathology Bi-Annual Progress Reports: <ul style="list-style-type: none"> ◦ Individual #31 – None found for September 2011 – March 2012. • Occupational Therapy Bi-Annual Progress Reports: <ul style="list-style-type: none"> ◦ Individual #31 – None found for May 2011 - October 2011. • Quarterly Nursing Reports: <ul style="list-style-type: none"> ◦ Individual #12 – None found for April 2011 - March 2012. 	<p>Provider: State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>within one week of the written request, the Case Management Provider Agency is to contact the respective DDSD Regional Office in writing within one business day for assistance in obtaining required reports.</p> <p>(d) Assure at least quarterly that Crisis Prevention/Intervention Plans are in place in the residence and at the Provider Agency of the Day Services for all individuals who have chronic medical condition(s) with potential for life threatening complications and/or who have behavioral challenge(s) that pose a potential for harm to themselves or others.</p> <p>(e) Assure at least quarterly that a current Health Care Plan (HCP) is in place in the residence and day service site for individuals who receive Community Living or Day Services and who have a HAT score of 4, 5, or 6. During face-to-face visits and review of quarterly reports, the Case Manager is required to verify that the Health Care Plan is being implemented.</p> <p>(f) Assure that Community Living Services are delivered in accordance with standards, including responsibility of the IDT Members to plan for at least 30 hours per week of planned activities outside the residence. If this is not possible due to the needs of the individual, a goal shall be developed that focuses on appropriate levels of community integration. These activities do not need to be limited to paid supports but may include independent or leisure activities appropriate to the individual.</p>			
---	--	--	--

<p>(g) Perform annual satisfaction surveys with individuals regarding case management services. A copy of the summary is due each December 10th to the respective DDSD Regional Office, along with a description of actions taken to address suggestions and problems identified in the survey.</p> <p>(h) Maintain regular communication with all providers delivering services and products to the individual.</p> <p>(i) Establish and implement a written grievance procedure.</p> <p>(j) Notify appropriate supervisory personnel within the Provider Agency if concerns are noted during monitoring or assessment activities related to any of the above requirements. If such concerns are not remedied by the Provider Agency within a reasonable mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office and/or DHI as appropriate to the nature of the concern. This does not preclude Case Managers' obligations to report abuse, neglect or exploitation as required by New Mexico Statute.</p> <p>(k) Utilize and submit the "Request for DDSD Regional Office Intervention" form as needed, such as when providers are not responsive in addressing a quality assurance concern. The Case Management Provider Agency is required to keep a copy in the individual's file.</p> <p>(2) Case Managers and Case Management Provider Agencies are required to promote and comply with the Case Management</p>			
---	--	--	--

<p>Code of Ethics:</p> <p>(a) Case Managers shall provide the individual/guardian with a copy of the Code of Ethics when Addendum A is signed.</p> <p>(b) Complaints against a Case Manager for violation of the Code of Ethics brought to the attention of DDS will be sent to the Case Manager's supervisor who is required to respond within 10 working days to DDS with detailed actions taken. DDS reserves the right to forward such complaints to the IRC.</p>			
---	--	--	--

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>CMS Assurance – Qualified Providers – <i>The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.</i></p>			
<p>Tag # 1A37 Individual Specific Training - Case Manager: Awareness Level</p>	<p>Standard Level Deficiency</p>		
<p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Case Management Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <ul style="list-style-type: none"> • 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% 	<p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 1 of 22 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <ul style="list-style-type: none"> • Individual Specific Training (Awareness Level) (Case Manager #69) 	<p>Provider: State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

competency rating during the competency verification process.

Tag #1A40 - Provider Requirement Accreditation	Standard Level Deficiency		
<p>NMAC 7.26.6.6 OBJECTIVE: A. These regulations are being promulgated to promote and assure the provision of quality services to persons with developmental disabilities residing in community agencies. B. These regulations are being promulgated as part of a quality assurance initiative requiring all community agencies providing services to persons with developmental disabilities and contracting with the developmental disabilities division to be accredited by the commission on accreditation of rehabilitation facilities (CARF).</p> <p>7.26.6.14 CARF STANDARDS MANUAL FOR ORGANIZATIONS SERVING PEOPLE WITH DEVELOPMENTAL DISABILITIES: Community agencies governed by these regulations are required to meet applicable provisions of the most current edition of the "CARF Standards Manual for Organizations Serving People with Disabilities". Sections of the CARF standards may be waived by the Department when deemed not applicable to the services provided by the community agency.</p> <p>Long Term Services Division Policy - Accreditation of Long Term Services Division Funded Providers eff. August 30, 2004 A. Mandate for Accreditation The Department of Health, Long Term Services Division (hereafter referred to as the Division) will contract only with agencies/organizations accredited in compliance with this policy. 1. Within eighteen (18) months of an initial contract or change in exemption status as defined in this policy, the contractor must provide the Division with written</p>	<p>Based on observation and interview, the Agency failed to obtain the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (The Council) accreditation or the applicable waiver from the Developmental Disability Support Division.</p> <p>Observation of the Agency's office on May 1, 2012 found no evidence of a current CARF accreditation or DDS Waiver.</p> <p>When #52 was asked if the Agency had evidence of current CARF accreditation or a waiver from DDS the following was reported:</p> <ul style="list-style-type: none"> • #52 stated, "We have a waiver. I can see if we have something in writing from DDS." Documentation of the waiver was not provided to the Surveyor as of May 3, 2012. 	<p>Provider: State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>verification of accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (The Council).</p> <p>2. Except as provided in this policy, the Division may terminate its contract with a contractor that fails to maintain an accreditation status of at least one year, regardless of any appeal process available from CARF or the Council.</p>			
---	--	--	--

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>CMS Assurance – Financial Accountability – <i>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</i></p>			
<p>TAG #1A12 All Services Reimbursement (No Deficiencies)</p>			
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 Chapter 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ul style="list-style-type: none"> (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. <p>Billing for Case Management services was reviewed for 43 of 43 individuals. <i>Progress notes and billing records supported billing activities for the months of January, February, and March 2012.</i></p>			



SUSANA MARTINEZ, GOVERNOR

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

Date: July 5, 2012

To: Scott Newland, President
Provider: Unidas Case Management, Inc.
Address: 2403 San Mateo Blvd., NE W-17
State/Zip: Albuquerque, NM 87110

E-mail Address: rscottnewland@gmail.com

Region: Metro & Northeast
Survey Date: April 30 - May 3, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Case Management
Survey Type: Routine

Dear Mr. Newland,

Your request for a Reconsideration of Findings was received on June 8, 2012. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 4C12

Determination: The IRF committee is removing the original finding in the report of findings.

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

QMB Report of Findings – Unidas Case Management, Inc. –Metro & Northeast Regions – April 30 - May 3, 2012

Survey Report #: Q.12.4.DDW.D3434.(2 & 5).001.RTN.01. 146

Thank you.
Respectfully,

A handwritten signature in blue ink, appearing to read 'S. Good', with a stylized flourish at the end.

Scott Good
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair



SUSANA MARTINEZ, GOVERNOR

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

Date: August 10, 2012

To: Scott Newland, President
Provider: Unidas Case Management Inc.
Address: 2403 San Mateo Blvd., NE W-17
State/Zip: Albuquerque, NM 87110

E-mail Address: rscottnewland@gmail.com

CC: Kristin Pasquini-Johnson, QA Director
Address: 2403 San Mateo Blvd., NE W-17
State/Zip: Albuquerque, NM 87110

Region: Metro & Northeast
Survey Date: April 30 - May 3, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Case Management
Survey Type: Routine

Dear Mr. Newland,

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided were adequate to verify that previously cited survey Deficiencies have been corrected. However, please note that for Tag #4C15.1, for Individual #31, a SLP Plan was provided in lieu of a Bi-Annual Progress Report. This would not be sufficient since a separate report should be generated bi-annually and the plan provided did not include adequate information to be considered a bi-annual report. Please ensure that the correct documentation is obtained and filed. No documentation needs to be provided to this Plan of Correction Coordinator.

QMB Report of Findings – Unidas Case Management, Inc. –Metro & Northeast Regions – April 30 - May 3, 2012

Survey Report #: Q.12.4.DDW.D3434.(2 & 5).001.RTN.01. 146

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,



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

Q.13.1.DDW.D3434.(2 & 5).001.RTN.09.223