



SUSANA MARTINEZ, GOVERNOR

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

Date: March 1, 2012

To: Carolene McNeese, Executive Director
Provider: Visions Case Management, Inc.
Address: 1570 Pacheco B-7, Santa Fe
State/Zip: New Mexico, 87505

E-mail Address: cmcness@gwest.net
barbpribble@gwest.net

Region: Northeast
Survey Date: November 28 – December 2, 2011
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Case Management
Survey Type: Routine
Team Leader: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Maurice Gonzales, BA of Health Ed., Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. McNeese;

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:

Partial Compliance with Conditions of Participation

This determination is based on non compliance with one or more CMS waiver assurances at the Condition of Participation level as well as Standard level deficiencies identified in the attached QMB Report of Findings 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



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 – Visions Case Management, Inc. – Northeast Region – November 28 – December 2, 2011

Survey Report #: Q12.02.D1667.NE.001.RTN.01

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 505-222-8647 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,

Tony Fragua, BFA

Tony Fragua, BFA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: November 28, 2011

Present: **Visions Case Management, Inc.**
Barbara Pribble, Office Manager

DOH/DHI/QMB

Tony Fragua, BFA, Team Lead/Healthcare Surveyor
Maurice Gonzales, BA of Health Ed., Healthcare Surveyor

Exit Conference Date: December 1, 2011

Present: **Visions Case Management, Inc.**
Carol McNees, Executive Director
Barbara Pribble, Office Manager
Beth Marquez, Case Manager
Teresa Maestas, Case Manager
Tom Harmer, Administration

DOH/DHI/QMB

Tony Fragua, BFA, Team Lead/Healthcare Surveyor
Maurice Gonzales, BA of Health Ed., Healthcare Surveyor

DDSD - NE Regional Office

Charlene Cain, Northeast Regional Manager
Paul Schwalje, Regional Office Bureau Chief

Administrative Locations Visited Number: 1

Total Sample Size Number: 25
3 - Jackson Class Members
22 - Non-Jackson Class Members

Persons Served Records Reviewed Number: 25

Case Managers Interviewed Number: 8

Case Mgt Personnel Records Reviewed Number: 10

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 – Visions Case Management, Inc. – Northeast Region – November 28 – December 2, 2011

Survey Report #: Q12.02.D1667.NE.001.RTN.01

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 505-222-8647 or email at George.Perrault@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 POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
 - a. Electronically at George.Perrault@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 POC Coordinator.
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 Plan of Correction Coordinator 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: Visions Case Management, Inc. - Northeast Region
Program: Developmental Disabilities Waiver
Service: Case Management
Monitoring Type: Routine Survey
Date of Survey: November 28 – December 2, 2011

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 20 of 25 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"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Did not contain pharmacy Information (#2, 4 & 10) ◦ Did not contain name, phone number of guardian, relatives or conservator Information (#2) ◦ Did not contain physician’s name & phone number Information (#2 & 4) ◦ Did not contain Health Plan Information (#2 & 10) • Annual ISP <ul style="list-style-type: none"> ◦ Incomplete (#2 & 8) 	<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> <p>(1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;</p> <p>(2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge</p>	<ul style="list-style-type: none"> • ISP Assessment Checklist (#2, 4 & 14) • ISP Signature Page <ul style="list-style-type: none"> ◦ None Found (#2) ◦ Not fully constituted IDT (#8 & 15) • Individual Specific Training Section (ISP) (#2 & 10) • ISP Teaching & Support Strategies <ul style="list-style-type: none"> ◦ <i>Individual #13 - TASS not found for:</i> ◦ Outcome Statement #1 Live: "I want to host 4 parties for family and friends." <ul style="list-style-type: none"> ➢ "Assist ... planning her events, choosing meals, invite people to her events." ◦ Outcome Statement #2 Live: "I will actively participate in communicating my choices and desires to others." <ul style="list-style-type: none"> ➢ "...opportunity to choose activities in the community, choice making, 2 or 3 choices of activities." ◦ Outcome Statement #3 Work/Education/Volunteer: "I want a job directly working with people." <ul style="list-style-type: none"> ➢ "Job development will occur to find ... an appropriate job match. Continued support will occur towards independence on her current job until new job is found." ◦ Outcome Statement #4 Develop Relationship/Have Fun: "I will have a volunteer job, something I enjoy." <ul style="list-style-type: none"> ➢ "Make connections with people, develop meaningful roles or volunteer jobs in the community, develop friendships, meet new people, encourage to choose activities to participate in." 		
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<p>from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>	<ul style="list-style-type: none"> ◦ <i>Individual #15 - TASS not found for:</i> ◦ Outcome Statement # 1 Live: "I will assist with my personal care daily." <ul style="list-style-type: none"> ➤ "... assists with positioning during personal hygiene." ◦ <i>Individual #20 - TASS not found for:</i> ◦ Outcome Statement # 1 Live: "I will subscribe to get mail." <ul style="list-style-type: none"> ➤ "Send mail & postcards." ◦ Outcome Statement # 2 Work/Education/Volunteer: "I will become an active member of my church." <ul style="list-style-type: none"> ➤ "Explore group activities." ➤ "Join group activities." ◦ Outcome Statement # 3 Develop Relationships/Have Fun: "I will expand my activities at the Senior Center." <ul style="list-style-type: none"> ➤ "Participate in activity." • Positive Behavioral Plan (#8 & 13) • Positive Behavioral Crisis Plan (#14 & 25) • Speech Therapy Plan (#3, 8, 13 & 14) • Occupational Therapy Plan (#10 & 13) • Physical Therapy Plan (#10, 13, 14, & 24) • Health Assessment Tool (Electronic Comprehensive Health Assessment Tool) (#2 & 13) • Health Care Plans <ul style="list-style-type: none"> • <i>Diabetes</i> ◦ Individual #2 - According to e-CHAT 		
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	<p>(Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found.</p> <ul style="list-style-type: none"> • <i>Body Mass Index</i> <ul style="list-style-type: none"> ◦ Individual #14 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. ◦ Individual #15 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. ◦ Individual #20 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. ◦ Individual #21 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>Aspiration</i> <ul style="list-style-type: none"> ◦ Individual #20 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. ◦ Individual #21 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>Tube Feeding</i> <ul style="list-style-type: none"> ◦ Individual #21 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required 		
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	<p>to have a plan. No evidence of plan found.</p> <ul style="list-style-type: none"> • <i>Seizures</i> <ul style="list-style-type: none"> ◦ Individual #21 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>Gastrointestinal</i> <ul style="list-style-type: none"> ◦ Individual #21 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>Constipation</i> <ul style="list-style-type: none"> ◦ Individual #21 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>Fluid Restriction</i> <ul style="list-style-type: none"> ◦ Individual #21 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>Respiratory</i> <ul style="list-style-type: none"> ◦ Individual #24 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>HAT score level 5</i> <ul style="list-style-type: none"> ◦ Individual #8 - As indicated by HAT Score the individual is required to have a plan. No evidence of plans found. • Crisis Plans/Medical Emergency Response Plans <ul style="list-style-type: none"> • <i>Diabetes</i> 		
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	<ul style="list-style-type: none"> ◦ Individual #2 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. ◦ Individual #14 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>GERD</i> <ul style="list-style-type: none"> ◦ Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. No evidence of plan found. • <i>Aspiration</i> <ul style="list-style-type: none"> ◦ Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. No evidence of plan found. ◦ Individual #21 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>Falls</i> <ul style="list-style-type: none"> ◦ Individual #20 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>Tube Feeding</i> <ul style="list-style-type: none"> ◦ Individual #21 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>Seizures</i> 		
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	<ul style="list-style-type: none"> ◦ Individual #21 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>Gastrointestinal</i> <ul style="list-style-type: none"> ◦ Individual #21 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>Constipation</i> <ul style="list-style-type: none"> ◦ Individual #21 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • <i>Respiratory</i> <ul style="list-style-type: none"> ◦ Individual #24 - According to e-CHAT (Electronic Comprehensive Health Assessment Tool) the individual is required to have a plan. No evidence of plan found. • Special Health Care Needs: <ul style="list-style-type: none"> • Nutritional Plan <ul style="list-style-type: none"> ◦ Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. ◦ Individual #16 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. Other Individual Specific Evaluations & Examinations: <ul style="list-style-type: none"> • Psychiatric Evaluation <ul style="list-style-type: none"> ◦ Individual #20 - As indicated by the documentation reviewed, exam was 		
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	<p>completed on 11/19/2010. Follow-up was to be completed every 3 months. No documented evidence of the follow-up being completed was found.</p> <ul style="list-style-type: none"> • Neurological Evaluation <ul style="list-style-type: none"> ◦ Individual #20 - As indicated by the documentation reviewed, exam was completed on 5/03/2010. Follow-up was to be completed 1 year. No documented evidence of the follow-up being completed was found. • Nutritional Evaluation <ul style="list-style-type: none"> ◦ Individual #24 - Per documentation reviewed evaluation was completed on 5/11/2009. Follow-up was to be completed in 1 year. No documented evidence of the evaluation being completed was found. • Dental Exam <ul style="list-style-type: none"> ◦ Individual #1 - As indicated by the DDS file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found. ◦ Individual #2 - As indicated by the documentation reviewed, the exam was completed on 3/24/2010. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. ◦ Individual #4 -As indicated by the DDS file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found. ◦ Individual #8 - As indicated by the documentation reviewed, the exam was 		
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	<p>completed on 8/2010. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found.</p> <ul style="list-style-type: none"> ◦ Individual #10 - As indicated by the documentation reviewed, exam was completed on 1/12/2010. 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 1/22/2010. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. ◦ Individual #21 - As indicated by the documentation reviewed, exam was completed on 10/04/2010. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. ◦ Individual #23 - As indicated by the documentation reviewed, exam was completed on 5/2011. Follow-up was to be completed in 6 months. No documented evidence of the follow-up being completed was found. ◦ Individual #25 - As indicated by the documentation reviewed, exam was completed on 7/13/2010. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. 		
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	<ul style="list-style-type: none"> • Auditory Exam <ul style="list-style-type: none"> ◦ Individual #9 - As indicated by the documentation reviewed, exam was completed on 5/2011. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. ◦ Individual #7 - As indicated by the documentation reviewed, exam was completed on 2/17/2010. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. ◦ Individual #13 - As indicated by the documentation reviewed, Hearing Evaluation was requested by Doctor on 2/18/2010. No documented evidence of the exam being completed was found. • Vision Exam <ul style="list-style-type: none"> ◦ Individual #1 - As indicated by the DDS file matrix Vision Exams are to be conducted every other year. No documented evidence of exam was found. ◦ Individual #7 - As indicated by the documentation reviewed, exam was completed on 11/10/2010. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. ◦ Individual #13 - As indicated by the documentation reviewed, exam was completed on 5/2011. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. 		
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	<ul style="list-style-type: none"> ◦ Individual #18 - As indicated by the documentation reviewed, exam was completed on 8/25/2010. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. • Mammogram Exam <ul style="list-style-type: none"> ◦ Individual #1 - As indicated by the documentation reviewed, exam was completed on 6/22/2009. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. • Cholesterol & Blood Glucose <ul style="list-style-type: none"> ◦ Individual #24 - As indicated by the documentation reviewed, lab work was ordered on 9/02/2011. No documented evidence was found to verify it was completed. • Blood Levels <ul style="list-style-type: none"> ◦ Individual #24 - As indicated by the documentation reviewed, lab work was ordered on 9/02/2011 (Depakote levels). No documented evidence found to verify it was completed. • Positive Behavior Support Assessment (#8 & 9) • Speech/Language Therapy Evaluation (#8) • Occupational Therapy Evaluation (#10 & 13) • Physical Therapy Evaluation (#10, 12, 13, & 24) 		
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	<ul style="list-style-type: none">• Guardianship Documentation (#10)• Decision Justification Forms<ul style="list-style-type: none">◦ Individual #1 - As indicated by the documentation reviewed, Individual's Guardian was to decline the following examination; Neurology, Psychiatry, Vision, Audiology, Colonoscopy. Evidence was found indicating the IDT agreed to Guardians Preference to decline exams. No evidence found of Healthcare Decision Justification Form.		
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Tag # 4C02 Scope of Services - Primary Freedom of Choice	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 II. SCOPE OF CASE MANAGEMENT SERVICES: Case Management shall include, but is not limited to, the following services:</p> <p>T. Assure individuals obtain all services through the Freedom of Choice process.</p>	<p>Based on record review the Agency failed to maintain documentation assuring individuals obtained all services through the freedom of choice process for 1 of 25 individuals.</p> <p>No evidence was found of the following:</p> <ul style="list-style-type: none"> • Primary Freedom of Choice (#23) 	<p>Provider: State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

Tag # 4C07 Individual Service Planning	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</p> <p>E. Individualized Service Planning and Approval:</p> <p>(1) Individualized service planning is developed through a person-centered planning process in accordance with the rule governing ISP development (7.26.5 NMAC). A person-centered planning process shall be used to develop an ISP that includes:</p> <p>(a) Realistic and measurable desired outcomes for the individual as identified in the ISP which includes the individual's long-term vision, summary of strengths, preferences and needs, desired outcomes and an action plan and is:</p> <p>(i) An ongoing process, based on the individual's long-term vision, and not a one-time-a-year event; and</p> <p>(ii) Completed and implemented in response to what the IDT members learn from and about the person and involves those who can support the individual in achieving his or her desired outcomes (including family, guardians, friends, providers, etc.).</p> <p>(2) The Case Manager will ensure the ongoing assessment of the individual's strengths, needs and preferences and use this information to inform the IDT members and</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review the Agency failed to ensure Case Managers developed realistic and measurable desired outcomes for the individual as identified in the ISP which includes the individual's long-term vision, summary of strengths, preferences and needs, desired outcomes and an action plan for 9 of 25 Individuals.</p> <ul style="list-style-type: none"> • Individual #2: <ul style="list-style-type: none"> ◦ Live: "I want to expand my garden." Outcome was does not indicate how and/or when it would be completed. ◦ Work/Education/Volunteer: "I want to manage my own money." Outcome was does not indicate how and/or when it would be completed. • Individual #5: <ul style="list-style-type: none"> ◦ Live: "... reads out loud at home and in her community." Outcome was does not indicate how and/or when it would be completed. ◦ Work/Education/Volunteer: "... extends her hours at her current job." Outcome was does not indicate how and/or when it would be completed. • Individual #6: <ul style="list-style-type: none"> ◦ Live: "... will maintain his health and stay active." Outcome was does not indicate how and/or when it would be completed. 	<p>Provider: State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>guide the development of the plan.</p> <p>7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS:</p> <p>Each ISP shall contain...</p> <p>C. Outcomes:</p> <p>(1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP.</p> <p>(2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.</p>	<ul style="list-style-type: none"> ◦ Work/Education/Volunteer: "... will have meaningful role in the community." Outcome was does not indicate how and/or when it would be completed. • Individual #7: <ul style="list-style-type: none"> ◦ Live: "... will maintain his health and stay active." Outcome was does not indicate how and/or when it would be completed. ◦ Work/Education/Volunteer: "... will have meaningful role in the community." Outcome was does not indicate how and/or when it would be completed. • Individual #8: <ul style="list-style-type: none"> ◦ Work/Education/Volunteer: "... would like to understand work options and what retirement is." Outcome was does not indicate how and/or when it would be completed. • Individual #9: <ul style="list-style-type: none"> ◦ Live: "I will prepare my breakfast." Outcome was does not indicate how and/or when it would be completed. ◦ Work/Education/Volunteer: "I will increase my steps." Outcome was does not indicate how and/or when it would be completed. • Individual #10: <ul style="list-style-type: none"> ◦ Live: "I will maintain independence and health." Outcome was does not indicate how and/or when it would be completed. ◦ Work/Education/Volunteer: "I want to be more independent at work." Outcome 		
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	<p>was does not indicate how and/or when it would be completed.</p> <ul style="list-style-type: none"> • Individual #15: <ul style="list-style-type: none"> ◦ Work/Education/Volunteer: “I want to play the piano.” Outcome was does not indicate how and/or when it would be completed. • Individual #20: <ul style="list-style-type: none"> ◦ Live: “I will subscribe to get mail.” Outcome was does not indicate how and/or when it would be completed. • Individual #24: <ul style="list-style-type: none"> ◦ Work/Education/Volunteer: “To be employed.” Outcome was does not indicate how and/or when it would be completed. 		
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Tag # 4C08 ISP Development Process	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS - F. Case Manager ISP Development Process:</p> <p>(1) The Case Manager meets with the individual in advance of the ISP meeting in order to enable the person to review current assessment information, prepare for the meeting, plan to facilitate or co-facilitate the meeting if the individual wishes and to ensure greater and more informed participation.</p> <p>(2) The Case Manager will discuss and offer the optional Personal Plan Facilitation service to the individual to supplement the ISP planning process; if selected, the Case Manager will assist in obtaining this service through the FOC process. This service is funded within the individual's ARA.</p> <p>(3) The Case Manager convenes the IDT members and a service plan is developed in accordance with the rule governing ISP development (7.26.5 NMAC).</p> <p>(4) The Case Manager will advise the individual of his or her rights and responsibilities related to receipt of services, applicable federal and state laws and guidelines, DOH policies and procedures pertaining to the development and implementation of the ISP, confidentiality, abuse, neglect, exploitation, and appropriate grievance and appeal procedures. In addition, the Case Manager shall provide the individual and/or guardian with a copy of the Case Management Code of Ethics at this time.</p> <p>(5) The Case Manager will clarify the</p>	<p>Based on record review the Agency failed to ensure Case Managers provided and/or advised the individual and/or guardian with the following requirements for 1 of 25 individuals.</p> <p>Review of record found no evidence of the following:</p> <ul style="list-style-type: none"> • Rights & Responsibilities (#2) • Case Manager Code of Ethics (#2) 	<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>individual's long-term vision through direct communication with the individual, and if needed, through communication with family, guardians, friends and support providers and others who know the individual. Information gathered shall include, but is not limited to the following:</p> <ul style="list-style-type: none"> (a) Strengths; (b) Capabilities; (c) Preferences; (d) Desires; (e) Cultural values; (f) Relationships; (g) Resources; (h) Functional skills in the community; (i) Work interests and experiences; (j) Hobbies; (k) Community membership activities or interests; (l) Spiritual beliefs or interests; and (m) Communication and learning styles or preferences to be used in development of the individual's service plan. <p>(6) Case Managers shall operate under the presumption that all working age adults with developmental disabilities are capable of working given the appropriate supports. Individuals will be offered employment as a preferred day service over other day service options. It is the responsibility of the Case Manager and all IDT members to ensure that employment decisions are based on informed choices.</p> <p>(a) The Case Manager shall verify that all Jackson Class members who express an 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</p>			
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<p>twelve (12) months.</p> <p>(b) In cases when employment is not an immediate desired outcome, the ISP shall document the reasons for this decision and develop employment-related goals within the ISP that will be undertaken to explore employment options (e.g., volunteer activities, career exploration, situational assessments, etc.) This discussion related to employment issues shall be documented within the ISP or on the DDSD Decision Justification form.</p> <p>(c) In the context of employment, informed choices include the following:</p> <ul style="list-style-type: none"> (i) Information regarding the range of employment options available to the individual (ii) Information regarding self-employment and customized employment options (iii) Job exploration activities including volunteer work and/or trial work opportunities <p>(7) The Case Manager will ensure discussion on Meaningful Day activities for the individual in the ISP meeting, and reflect such discussion in the ISP “Meaningful Day Definition” section.</p> <p>(8) When a recipient of DD Waiver services has a HAT score of 4, 5, or 6, medical consultation shall be obtained for service planning and delivery, including the ISP and relevant Health Care and Crisis Prevention/Intervention Plans. Medical consultation may be from a Provider Agency Nurse, Primary Care Physician/Practitioner, Regional Office Nurse, Continuum of Care Nurses or Physicians including his or her Regional Medical Consultant and/or RN Nurse Case Manager.</p>			
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<p>(9) For new allocations, the Case Manager will submit the ISP to NMMUR only after a MAW letter has been received, indicating the individual meets financial and LOC eligibility.</p> <p>(10) The Case Manager, with input from each Provider Agency, shall complete the Individual Specific Training Requirements section of the ISP form listing all training needs specific to the individual.</p> <p>(11) The Case Manager shall complete the initial ISP development within ninety (90) days as required by DDSD.</p>			
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Tag # 4C09 Secondary FOC	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS G. Secondary Freedom of Choice Process</p> <p>(1) The Case Management Provider Agency will ensure that it maintains a current Secondary Freedom of Choice (FOC) form that includes all service providers offering services in that region.</p> <p>(2) The Case Manager will present the Secondary FOC form to the individual or authorized representative for selection of direct service providers.</p> <p>(3) At least annually, at the time rights and responsibilities are reviewed, individuals and guardians served will be reminded that they may change providers at any time, as well as change types of services. At this time, Case Managers shall offer to review the current Secondary FOC list with individuals and guardians served. If they are interested in changing, a new FOC shall be completed.</p>	<p>Based on record review, the Agency failed to maintain current Secondary Freedom of Choice documentation and ensure individuals obtained all services through the Freedom of Choice Process for 1 of 25 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"> ◦ Physical Therapy (#17) 	<p>Provider: State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

Tag # 4C10 Apprv. MAD 046 & Budget	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>H. Case Management Approval of the MAD 046 Waiver Review Form and Budget</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(4) The Case Manager shall respond to NMMUR within specified timelines whenever a MAD 046 is returned for corrections or additional information.</p>	<p>Based on record review the Agency failed to maintain documentation ensuring the Case Manager completed the MAD046 Waiver Review Form for 2 of 25 individuals.</p> <p>The following item was not found:</p> <ul style="list-style-type: none"> • MAD 046 <ul style="list-style-type: none"> ◦ Supported Employment (#14) ◦ Supported Living – Sleep Awake (#20) 	<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>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 25 individuals.</p> <p>Record review of Agency files found no evidence of Case Manager Monthly Case Notes for the following:</p> <ul style="list-style-type: none"> • Individual #2 - None found for 10/2011 • Individual #10 - None found for 5/2011 & 6/2011 <p>Record review of Agency files found no evidence indicating face-to-face visits were completed as required for the following individuals:</p> <ul style="list-style-type: none"> • Individual #2 – No Face to Face Visit Summary Forms found for 10/2011. • Individual #10 – No Face to Face Visit Summary Forms found for May 2011 & June 2011. <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 (Jackson)</p> <ul style="list-style-type: none"> • No site visit was noted between 5/2011 - 10/2011. <ul style="list-style-type: none"> ◦ 10/20/2011 – 4- 5pm – 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>(d) For adults who are not Jackson Class members and who do not receive Community Living Services, at least one face-to-face visit per quarter shall be in his or her home;</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</p>	<ul style="list-style-type: none"> ◦ 10/27/2011 – 1:45- 2:45pm – home visit ◦ 9/23/2011 – 10- 11am – home visit ◦ 9/28/2011 – 3:30-4:30pm – home visit ◦ 8/17/2011 – 2:15-3pm – home visit ◦ 8/25/2011 – 2:15-3:30 – home visit ◦ 7/20/2011 – 3:15-4:15 – home visit ◦ 7/28/2011 – 10:30-11am – home visit ◦ 6/28/2011 – 10-11am – home visit ◦ 6/30/2011 – 2-3pm – home visit ◦ 5/5/2011 – 12-1pm – home visit ◦ 5/25/2011 – 3:30-4pm – home visit <p>Based on the record review the Agency failed to Communicate with IDT members to ensure the individual received maximum benefit of his or her services. The Case Manager failed to ensure that any needed adjustments to the service plan are made, where indicated.</p> <ul style="list-style-type: none"> • Documentation indicated Individual #15 received In-Home Day Habilitation services from 1/15/2011 – 12/2/2011 without prior approval from DDSD Northeast Regional Office. No evidence was found to indicate a request was made from Community Living provider or the Case Manager during that time. Case Manager failed to submit a completed DDSD Prior Approval Form for In-Home Adult Habilitation, as required by 		
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<p>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.</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>	<p>standard.</p>		
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Tag # 4C15.1 - QA Requirements - Bi-Annual Reports & Provider Quarterly Reports	Standard Level Deficiency		
<p>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</p> <p>C. Quality Assurance Requirements: Case Management Provider Agencies will use an Internal Quality Assurance and Improvement Plan that must be submitted to and reviewed by the Statewide Case Management Coordinator, that shall include but is not limited to the following:</p> <p>(1) Case Management Provider Agencies are to:</p> <p>(a) Use a formal ongoing monitoring protocol that provides for the evaluation of quality, effectiveness and continued need for services and supports provided to the individual. This protocol shall be written and its implementation documented.</p> <p>(b) Assure that reports and ISPs meet required timelines and include required content.</p> <p>(c) Conduct a quarterly review of progress reports from service providers to verify that the individual's desired outcomes and action plans remain appropriate and realistic.</p> <p>(i) If the service providers' quarterly reports are not received by the Case Management Provider Agency within fourteen (14) days following the end of the quarter, the Case Management Provider Agency is to contact the service provider in writing requesting the report within one week from that date.</p>	<p>Based on record review, the Agency failed to ensure that reports and ISP's meet required timelines and include the required contents for 15 of 25 individuals.</p> <p>The following quarterly/bi-annual reports were not found:</p> <ul style="list-style-type: none"> • Community Living Annual Assessment <ul style="list-style-type: none"> ◦ Individual #14 – None found for October 2010 – October 2011. • Supported Living Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #8 – None found for October 2010 – March 2011. ◦ Individual #20 – None found for December 2010 – October 2011. ◦ Individual #24 – None found for August 2010 – November 2011; July 2011 – September 2011. • Supported Living Annual Assessment <ul style="list-style-type: none"> ◦ Individual #8 – None found for December 2009 – December 2010. • Family Living Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #4 – None found for December 2010 – May 2011. ◦ Individual #10 – None found for November 2010 – October 2011. ◦ Individual #16 – None found for November 2010 – January 2011. 	<p>Provider: State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> <p>Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.</p>	

<p>(ii) If the quarterly report is not received within one week of the written request, the Case Management Provider Agency is to contact the respective DDSD Regional Office in writing within one business day for assistance in obtaining required reports.</p> <p>(d) Assure at least quarterly that Crisis Prevention/Intervention Plans are in place in the residence and at the Provider Agency of the Day Services for all individuals who have chronic medical condition(s) with potential for life threatening complications and/or who have behavioral challenge(s) that pose a potential for harm to themselves or others.</p> <p>(e) Assure at least quarterly that a current Health Care Plan (HCP) is in place in the residence and day service site for individuals who receive Community Living or Day Services and who have a HAT score of 4, 5, or 6. During face-to-face visits and review of quarterly reports, the Case Manager is required to verify that the Health Care Plan is being implemented.</p> <p>(f) Assure that Community Living Services are delivered in accordance with standards, including responsibility of the IDT Members to plan for at least 30 hours per week of planned activities outside the residence. If this is not possible due to the needs of the individual, a goal shall be developed that focuses on appropriate 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</p>	<ul style="list-style-type: none"> • Family Living Annual Assessment <ul style="list-style-type: none"> ◦ Individual #6 – None found for March 2010 – March 2011. ◦ Individual #10 – None found for September 2010 – September 2011. ◦ Individual #21 – None found for September 2010 – September 2011. • Independent Living Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #2 – None found for April 2011 – September 2011. • Independent Living Annual Assessment <ul style="list-style-type: none"> ◦ Individual #2 – None found for February 2010 – February 2011. • Community Inclusion - Adult Habilitation Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #8 – None found for October 2010 – March 2011. ◦ Individual #16 – None found for November 2010 – January 2011. • Community Inclusion - Community Access Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #2 – None found for April 2011 – September 2011. • Community Inclusion - Community Access Annual Assessment: <ul style="list-style-type: none"> ◦ Individual #2 – None found for February 2010 – February 2011. ◦ Individual #3 – None found for October 2010 – October 2011. ◦ Individual #6 – None found for March 2010 		
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<p>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</p>	<p>– March 2011.</p> <ul style="list-style-type: none"> ◦ Individual #9 – None found for May 2010 – May 2011. <p>• Community Inclusion - Supported Employment Quarterly Reports:</p> <ul style="list-style-type: none"> ◦ Individual #8 – None found for January 2011 – March 2011; August 2011 – October 2011. ◦ Individual #10 – None found for November 2010 - October 2011. <p>• Behavior Consultation Quarterly Reports:</p> <ul style="list-style-type: none"> ◦ Individual #8 – None found for January 2011 – June 2011. ◦ Individual #15 – None found for November 2010 – January 2011. ◦ Individual #20 – None found for August 2011 – October 2011. <p>• Speech & Language Pathology Bi-Annual Progress Reports:</p> <ul style="list-style-type: none"> ◦ Individual #8 – None found for November 2010 – May 2011. ◦ Individual #13 – None found for May 2011 – November 2011. <p>• Occupational Bi-Annual Progress Reports:</p> <ul style="list-style-type: none"> ◦ Individual #13 – None found for May 2011 – November 2011. <p>• Physical Bi-Annual Progress Reports:</p> <ul style="list-style-type: none"> ◦ Individual #12 – None found for May 2011 – November 2011. 		
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<p>and comply with the Case Management Code of Ethics:</p> <p>(a) Case Managers shall provide the individual/guardian with a copy of the Code of Ethics when Addendum A is signed.</p> <p>(b) Complaints against a Case Manager for violation of the Code of Ethics brought to the attention of 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.</p>	<ul style="list-style-type: none"> ◦ Individual #13 – None found for May 2011 – November 2011. ◦ Individual #20 – None found for November 2010 – May 2011. ◦ Individual #24 – None found for November 2010 – May 2011. <p>• Quarterly Nursing Reports; Review of Progress with update on Healthcare Plans & Medical Emergency Response Plans:</p> <ul style="list-style-type: none"> ◦ Individual #2 – None found for November 2010 – November 2011. 		
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Level of Care – Initial and annual Level of Care (LOC) evaluations are completed within timeframes specified by the State.			
Tag # 4C04 Assessment Activities	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</p> <p>B. Case Management Assessment Activities: Assessment activities shall include but are not limited to the following requirements:</p> <p>(1) Complete and compile the elements of the Long Term Care Assessment Abstract (LTCAA) packet to include:</p> <p>(a) LTCAA form (MAD 378);</p> <p>(b) Comprehensive Individual Assessment (CIA);</p> <p>(c) Current physical exam and medical/clinical history;</p> <p>(d) Norm-referenced adaptive behavioral assessment; and</p> <p>(e) A copy of the Allocation Letter (initial submission only).</p> <p>(2) Prior to service delivery, obtain a copy of the Medical Assistant Worker (MAW) letter to verify that the county Income Support Division (ISD) office of the Human Services Department (HSD) has completed a determination that the individual meets</p>	<p>Based on record review, the Agency failed to complete and compile the elements of the Long Term Care Assessment Abstract (LTCAA) packet for 2 of 25 individuals.</p> <p>The following items were not found and/or incomplete:</p> <ul style="list-style-type: none"> • Annual Physical (#8 & 12) 	<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>financial and medical eligibility to participate in the DD Waiver program.</p> <p>(3) Provide a copy of the MAW letter to service providers listed on the ISP budget (MAD 046).</p>			
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Tag # 4C06 Review & Approval of the LTCAA Intervening Two Years	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>D. Case Management Review and Approval of the LTCAA: Case Management Provider agencies shall ensure that Case Managers conduct a complete and comprehensive LOC review for the intervening two years that the NMMUR is not required to review and approve the LTCAA. The comprehensive LOC shall include:</p> <p>(1) A new LTCAA;</p> <p>(2) A new history and physical;</p> <p>(3) An update to the Client Individual Assessment (CIA); and</p> <p>(4) A review of the norm-referenced adaptive behavioral assessment (current within three years), to determine if it still reflects the individual's functional level. If yes, the assessment shall be filed with the current LOC packet, and if not, it shall be re-administered. During these two years, it is the responsibility of the Case Manager to send a copy of the approved LOC to the appropriate ISD office for the individual's annual reassessment of Medicaid eligibility. Case Management Provider Agencies shall review a sample of LTCAAs at least annually to verify accuracy and appropriateness of the eligibility determination.</p>	<p>Based on record review, the Agency failed to ensure that Case Managers conduct a complete and comprehensive Level of Care review for the intervening two years that the NMMUR is not required to review and approve the LTCAA for 3 of 25 individuals.</p> <p>The following items were not found, not current and/or incomplete:</p> <ul style="list-style-type: none"> • Adaptive Behavior Scale (ABS) (#2, 8 & 10) 	<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>	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>CMS Assurance – Qualified Providers – <i>The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.</i></p>			
<p>Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training</p>	<p>Standard Level Deficiency</p>		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>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</p>	<p>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 1 of 25 individuals.</p> <ul style="list-style-type: none"> • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#2) 	<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>	

consumer, family member or legal guardian shall sign this at the time of orientation.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>CMS Assurance – Health and Welfare – <i>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.</i></p>			
<p>Tag # 1A03 CQI System</p>	<p>Standard Level Deficiency</p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS 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:</p> <ol style="list-style-type: none"> (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents 	<p>Based on record review and interview, the Agency failed to establish and implement a functional quality improvement system, as it relates specifically to case management.</p> <p>Review of the Agency's Quality Improvement plan did not contain the following:</p> <ul style="list-style-type: none"> • 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. <p>Review of the Agency's QA/QI Plan indicated the following:</p> <p>"VISIONS CASE MANAGEMENT, INC. QUALITY ASSURANCE POLICY AND PROCEDURES AND QUALITY IMPROVEMENT PLAN:</p> <p>INTERNAL QUALITY ASSURANCE/IMPROVEMENT PLAN JAN. 2011:</p> <p>DATA COLLECTION: The Visions Document Specialist will review 100% of all Visions client files yearly at the annual ISP cycle for client document required</p>	<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>leading to adverse health events;</p> <p>(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;</p> <p>(6) Quality and completeness documentation; and</p> <p>(7) Trends in individual and guardian satisfaction.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>DDSD DDW Std. Chapter 4.IV.C.1 Continuous Quality Management System:</p> <p>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:</p> <ul style="list-style-type: none"> • 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. <p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>E. Quality Improvement System for Community Based Service Providers: The community based service provider shall establish and implement a quality improvement</p>	<p>to be maintained by DOH/LTSD DD Waiver Standards.</p> <p><u>COMPLICATIONS AND ANALYSIS:</u></p> <p>The Document Specialist will compile and distribute File Reviews to the assigned case manager at the monthly QA meeting. The case manager has until the next monthly QA meeting for analysis. After researching the case manager will correct and/or request missing documentation before handing back to the Document Specialist. The Document Specialist then retains a copy for The File Review Binder and a copy is also maintained in the client file for future reference.</p> <p><u>IMPLEMENTATION OF IMPROVEMENTS:</u></p> <p>The Document Specialist reports any outstanding review to the QA Coordinator who addresses these reviews with the individual case manager for correction. The Document Specialist also directly communicates monthly information at the QA staffing to the case managers, focusing on any trends in document procurement that need improvement. Solutions are developed and implemented accordingly such as sending request forms to providers for missing documentation.</p> <p><u>PLAN CYCLE:</u></p> <p>This cycle is reviewed monthly and annually to ensure that 100% of all Visions Case Management client files are reviewed and missing and updated documentation is requested and obtained.”</p> <p>When asked to describe the Agency's Internal Quality Assurance & Improvement Plan addressing monitoring. The following was reported:</p>		
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<p>system for reviewing alleged complaints and incidents. The incident management system 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:</p> <ul style="list-style-type: none"> (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. 	<ul style="list-style-type: none"> • Executive Director (#51) & Document Specialist (#50) stated, "17 to 20 case files are reviewed at least every two months, 100% once a year. Missing documents should be in file. Strong follow up is not there, it's something we need to work on." <p>Review of evidence provided on-site did not indicate the agency was meeting their own level of QA/QI.</p>		
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Tag # 1A29 Complaints / Grievances - Acknowledgement	Standard Level Deficiency		
<p>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].</p> <p>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]</p> <p>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</p>	<p>Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 25 individuals.</p> <ul style="list-style-type: none"> Grievance/Complaint Procedure Acknowledgement (#2) 	<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>	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>CMS Assurance – Financial Accountability – <i>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</i></p>			
<p>Tag # 4C21 Case Management Reimbursement</p>	<p>Standard Level Deficiency</p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed, which contained the required information for 1 of 25 individuals. Individual #2 October 2011 • The Agency billed 1 units of Case Management (T2022) on 10/2011. No Documentation received to justify 1 unit billed.</p>	<p>Provider: State your Plan of Correction for the findings in this Tag <i>above</i> this line.</p> <hr/> Enter your Quality Assurance/Quality Improvement processes <i>below</i> the line.	

<p>Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4. V. CASE MANAGEMENT SERVICES REIMBURSEMENT - A. Billable Unit</p> <p>(1) Reimbursement to the Case Management Provider Agency is based upon a monthly rate for a maximum of 12 months per ISP year.</p> <p>(2) The Case Management Provider Agency shall provide and document at least one hour of case management services per individual served, and a monthly average of at least three (3) hours of DD Waiver service per individual, including face-to-face contacts, across the caseload of each Case Manager. A Case Management Provider Agency cannot bill for an individual for whom a face-to-face contact did not take place during the month.</p> <p>(3) Exceptions to the three-hour average are allowed if the Case Manager is on approved leave, as long as a Provider Agency colleague or supervisor has maintained essential duties during his or her absence, including mandated face-to-face visits.</p> <p>(4) Partial units are paid when the individual transitions from one Case Management Provider Agency to another during the month, and a Case Manager provides at least one hour of billable service including face-to-face contact during that calendar month. The monthly rate is pro-rated</p>			
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<p>based on the number of days the individual was with the Case Management Provider Agency.</p> <p>B. Billable Services: The following activities are deemed to be billable services:</p> <p>(1) All services and supports within the Case Management Scope of Services; and</p> <p>(2) Case Management may be provided at the same time on the same day as any other service.</p>			
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SUSANA MARTINEZ, GOVERNOR



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

Date: April 16, 2012

To: Carolene McNees, Executive Director
Provider: Visions Case Management, Inc.
Address: 1570 Pacheco B-7, Santa Fe
State/Zip: New Mexico, 87505

E-mail Address: cmcness@qwest.net

Region: Northeast
Survey Date: November 28 – December 2, 2011
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Case Management
Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Ms. McNees,

Your request for a Reconsideration of Findings was received on March 6, 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 # 1A08

QMB Report of Findings – Visions Case Management, Inc. – Northeast Region – November 28 – December 2, 2011

Survey Report #: Q12.02.D1667.NE.001.RTN.01

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied, deficiencies noted in tag 1A08 regarding Individual #13 were disputed by your agency as “#3.”

Regarding Tag # 4C07

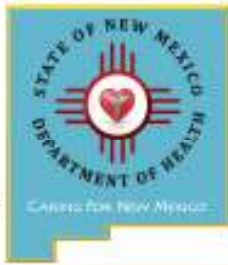
Determination: The IRF committee is removing the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the document submitted it was discovered the citation in the original report of findings should have been for Individual #7, but were reported in error as number 6.

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.

Thank you.
Respectfully,



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



SUSANA MARTINEZ, GOVERNOR

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

Date: May 10, 2012

To: Carolene McNees, Executive Director
Provider: Visions Case Management, Inc.
Address: 1570 Pacheco B-7
State/Zip: Santa Fe, New Mexico, 87505

E-mail Address: cmcness@qwest.net
barbpribble@qwest.net

Region: Northeast
Survey Date: November 28 – December 2, 2011
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Case Management
Survey Type: Routine

Dear Ms. McNees;

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Deputy Chief
Quality Management Bureau/DHI

