

Date: February 25, 2011

To: Grace Aragon, Executive Director  
Provider: El Paraiso Management Services, LLC  
Address: 901 Rio Grande Blvd, Suite D022A  
State/Zip: Albuquerque, New Mexico 87104

E-mail Address: [garagon001@aol.com](mailto:garagon001@aol.com)

Region: Metro  
Survey Date: January 18 – 19, 2011  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Case Management  
Survey Type: Initial  
Team Leader: Stephanie R. Martinez de Berenger, M.P.A, GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Maurice Gonzales, B.S, Health Ed, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Wanda Durant, Case Manager Coordinator, Developmental Disabilities Supports Division

Dear Ms. Aragon;

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 contracts. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

**Quality Management Compliance Determination:**

The Division of Health Improvement is issuing your agency a determination of “Non-Compliance with Conditions of Participation.”

**Plan of Correction:**

The attached Report of Findings identifies deficiencies found during your agency’s compliance review. You are required to complete and implement a 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. The response is due to the parties below within 10 working days of the receipt of this letter:

- 1. Quality Management Bureau, Attention: Plan of Correction Coordinator  
5301 Central Ave. NE Suite 400 Albuquerque, NM 87108**
- 2. Developmental Disabilities Supports Division Regional Office for region of service surveyed**



*“Assuring safety and quality of care in New Mexico’s health facilities and community-based programs.”*  
**Roger Gillespie, Acting Division Director • Division of Health Improvement**  
Quality Management Bureau • 5301 Central Ave. NE Suite 400 • Albuquerque, New Mexico 87108  
(505) 222-8623 • FAX: (505) 222-8661 • <http://dhi.health.state.nm.us>

QMB Report of Findings – El Paraiso Management Services, LLC – Metro Region – January 18 - 19, 2011

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 working days. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as all remedies must still be completed within 45 working days of the receipt of this letter.

Failure to submit, complete or implement your Plan of Correction within the 45 day required time frames 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 working days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

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

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 working days. 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,

*Stephanie R. Martinez de Berenger, M.P.A. GCDF*

Stephanie R. Martinez de Berenger, M.P.A. GCDF  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: January 18, 2011

Present: **El Paraiso Case Management**  
Grace Aragon, Executive Director  
Deanne Giron, Case Manager

**DOH/DHI/QMB**  
Stephanie R. Martinez de Berenger, MPA,GCDF, Team Lead/Healthcare Surveyor  
Maurice Gonzales, BS Health Ed, Healthcare Surveyor

**DDSD – Metro Regional Office**  
Wanda Durant, Case Manager Coordinator

Exit Conference Date: January 19, 2011

Present: **Agency Name**  
Grace Aragon, Executive Director  
Deanne Giron, Case Manager

**DOH/DHI/QMB**  
Stephanie R. Martinez de Berenger, MPA,GCDF, Team Lead/Healthcare Surveyor  
Maurice Gonzales, BS Health Ed, Healthcare Surveyor

**DDSD – Metro Regional Office**  
Wanda Durant, Case Manager Coordinator

Administrative Locations Visited Number: 1

Total Sample Size Number: 2  
0 – Jackson Class Members  
2 - Non-Jackson Class Members

Case Managers Interviewed Number: 1

Records Reviewed (Persons Served) Number: 2

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

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

### **Introduction:**

After a QMB Compliance Review, your QMB Report of Findings will be sent to you via US 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 days will be referred to the Internal Review Committee [IRC] for 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](mailto:George.Perrault@state.nm.us). Requests for technical assistance must be requested through your DDS Regional Office.

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) days of receiving your report. The POC process cannot resolve disputes regarding findings. 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. (see page 3, DDW standards, effective; April 1, 2007, Chapter 1, Section I Continuous Quality Management System)

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 you submit needs to address **each deficiency** in the two right hand columns with:

1. How the corrective action will be accomplished for all cited deficiencies in the report of findings;
2. How your Agency will identify all other individuals having the potential to be affected by the same deficient practice;
3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur and corrective action is sustained;
4. How your Agency plans to monitor corrective actions utilizing its continuous Quality Assurance/Quality Improvement Plan to assure solutions in the plan of correction are achieved and sustained, including (if appropriate):
  - Details about how and when Consumer and Personnel files are audited by Agency personnel to ensure they contain required documents;
  - 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, Root Cause Analyses about why Targets were not met, and remedies implemented.
5. The individual's title responsible for the Plan of Correction and completion date.

**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). Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 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.

### **Plan of Correction Submission Requirements**

1. Your 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. If you have 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](mailto:George.Perrault@state.nm.us)
  - b. Faxed to 505-222-8661, or
  - c. Mailed to QMB, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not send supporting documentation to QMB until after your POC has been approved by QMB.
6. QMB will notify you when your POC has been "approve" or "denied."
  - a. 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 working 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 that your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 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.
8. 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.

### ***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, fax, or electronically on disc or 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; hard copies or scanned and electronically submitted copies are fine. 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.

## QMB Scope and Severity Matrix

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

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

### Scope and Severity Definitions:

- **Isolated:**  
A deficiency that is limited to 1% to 15% of the sample, usually impacting few individuals in the sample.
- **Pattern:**  
A deficiency that impacts a number or group of individuals from 16% to 79% of the sample is defined as a pattern finding. Pattern findings suggest the need for system wide corrective actions.
- **Widespread:**  
A deficiency that impacts most or all (80% to 100%) of the individuals in the sample is defined as widespread or pervasive. Widespread findings suggest the need for system wide corrective actions as well as the need to implement a Continuous Quality Improvement process to improve or build infrastructure. Widespread findings could be referred to the Internal Review Committee for review and possible actions or sanctions.

## QMB Determinations of Compliance

- “Substantial Compliance with Conditions of Participation”

The QMB determination of “Substantial Compliance with Conditions of Participation” indicates that a provider is in substantial compliance with all ‘Conditions of Participation’ and other standards and regulations. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals’ health and safety. To qualify for a determination of Substantial Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation.

- “Non-Compliance with Conditions of Participation”

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

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

- “Sub-Standard Compliance with Conditions of Participation”:

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

- Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
- Any finding of actual harm or Immediate Jeopardy.

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

## **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 that surveyors have clarified issues and/or requested missing information before completing the review. Regardless, there may still be instances where the provider disagrees with a specific finding. 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 working days** of receipt of the final report.
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.

### **The following limitations apply to the IRF process:**

- The request for an IRF and all supporting evidence must be received within 10 days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed 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 QMB compliance determination or the length of their DDS provider contract.

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is 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:** El Paraiso Management Services, LLC – Metro Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Case Management  
**Monitoring Type:** Initial Survey  
**Date of Survey:** January 18 – 19, 2011

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<p><b>Tag # 1A05 (CoP) General Requirements</b></p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> 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.</p> <p><b>A. General Requirements:</b></p> <p>(2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDS policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.</p>	<p><b>Scope and Severity Rating: F</b></p> <p>Based on record review and interview, the Agency failed to develop and implement written policies and procedures that comply with all DDS policies and procedures.</p> <p>Review of the Agency’s policies and procedures, found no evidence of the following:</p> <ul style="list-style-type: none"> <li>• “Policy &amp; Procedure for Agency’s complaint procedure</li> <li>• “Policy &amp; Procedure for training, supervision and corrective action.</li> </ul> <p>When #41 was asked if the Agency had policies and procedures regarding Agency’s Compliant Process and the Agency’s Training, supervision and corrective action, the following was reported:</p> <ul style="list-style-type: none"> <li>• #41 stated, “We do not have the complaint procedure and the training, supervision and corrective action policies in our policy &amp; procedure book at this time.”</li> </ul>		

Tag # 1A08 Agency Case File	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> 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.</p> <p><b>D. Provider Agency Case File for the Individual:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <ol style="list-style-type: none"> <li>(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;</li> <li>(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);</li> <li>(3) Progress notes and other service delivery documentation;</li> <li>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</li> <li>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the</li> </ol>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 1 of 2 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"> <li>• ISP Assessment Checklist (#2)</li> <li>• Health Assessment Tool (#2)</li> <li>• <b>Health Care Plans</b> <ul style="list-style-type: none"> <li>• Cardiac Condition: <ul style="list-style-type: none"> <li>◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> <li>• Diabetes: <ul style="list-style-type: none"> <li>◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> </ul> </li> </ul> <p><b>Other Individual Specific Evaluations &amp; Examinations:</b></p> <ul style="list-style-type: none"> <li>• <b>Dental Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #2 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found</li> </ul> </li> </ul>		

<p>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> <ul style="list-style-type: none"> <li>(a) Complete file for the past 12 months;</li> <li>(b) ISP and quarterly reports from the current and prior ISP year;</li> <li>(c) Intake information from original admission to services; and</li> <li>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</li> </ul>			
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<b>Tag # 1A37 Individual Specific Training - Case Manager Awareness Level</b>	<b>Scope and Severity Rating: A</b>		
<p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title:</b> Training Requirements for Case Management Agency Staff Policy - <b>Eff. March 1, 2007</b></p> <p><b>II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified case managers.</p> <p>B. Case management staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</p> <p>C. Case management staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p> <p>D. In addition to the applicable requirements described in policy statements B – C (above), case managers and case management supervisors shall complete DDSD-approved core curriculum training...</p> <p>E. Substitutes shall comply with the training requirements of the staff for whom they are substituting.</p> <p>◦ F. To complete a core curriculum-training course, trainees shall achieve 100% competency rating during the competency verification process.</p>	<p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 1 of 1 agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <ul style="list-style-type: none"> <li>• Individual Specific Training (Awareness Level) (#40)</li> </ul>		

<b>Tag # 4C07 - Individual Service Planning</b>	<b>Scope and Severity Rating: D</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</b></p> <p><b>E. Individualized Service Planning and Approval:</b></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 guide the development of the plan.</p> <p><b>7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF</b></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 1 of 2 Individuals.</p> <p>The following was found with regards to ISP Outcomes:</p> <ul style="list-style-type: none"> <li>• Individual #2: <ul style="list-style-type: none"> <li>◦ "I will join a volunteer organization and give back to my community through volunteer work." Outcome does not indicate how or when it would be completed.</li> <li>◦ "I will improve my bowling scores." Outcome does not indicate how or when it would be completed.</li> <li>◦ "Individual with staff support will train staff on her healthcare." Outcome does not indicate how or when it would be completed.</li> </ul> </li> </ul>		

**INDIVIDUAL SERVICE PLANS:** Each ISP shall contain...

C. Outcomes:

(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.

(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.

Tag # 4C17 (CoP) - Case Manager Qualifications - Required Training	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>E. Case Manager Qualifications:</b> Case Managers, whether subcontracting or employed by a Provider Agency, shall meet these requirements:</p> <p>(1) Case Managers shall possess these qualifications: ...</p> <p>(2) Within specified timelines, Case Managers shall meet the requirements for training specified in the DDSD policy governing the training requirements for Case Managers serving individuals with developmental disabilities. All Case Management Provider Agencies are required to report required personnel training status to the DDSD Statewide Training Database as follows:</p> <p>(a) Initial comprehensive personnel status report (name, date of hire, identification number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; and</p> <p>(b) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, or agency position changes, and name changes.</p> <p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Case Management Agency Staff Policy - Eff. March 1, 2007</b></p> <p><b>II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent</p>	<p>Based on record review, the Agency failed to ensure that Training requirements were met for 1 of 1 Case Managers.</p> <p>Review of Case Manager training records found no evidence of the following required DOH/DDSD trainings being completed:</p> <ul style="list-style-type: none"> <li>• Person-Centered Planning in New Mexico (2-Days) (#40)</li> </ul>		

and qualified case managers.

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

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

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

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

F. To complete a core curriculum-training course, trainees shall achieve 100% competency rating during the competency verification process.

**ADDITIONAL FINDINGS: Reimbursement Deficiencies**

**BILLING  
TAG #1A12**

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION**

**B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:

- (1) Date, start and end time of each service encounter or other billable service interval;
- (2) A description of what occurred during the encounter or service interval; and
- (3) The signature or authenticated name of staff providing the service.

Billing for Case Management services was reviewed for 2 of 2 individuals. Progress notes and billing records supported billing activities for the months of October, November and December 2010