

Katrina Hotrum
Deputy Secretary

Jessica Sutin
Deputy Secretary

Michael Mulligan
Acting Deputy Secretary

Karen Armitage, MD
Chief Medical Officer

Date: June 21, 2010

To: Laura Pate, Executive Director
Provider: Excel Case Management Inc.
Address: P.O. Box 2839, 626 East Main
State/Zip: Farmington, New Mexico 87499

E-mail Address: lp@excelcasemanagement.com

CC: Dave Dunaway, Board Chair
Address: 804 West 24th St.
State/Zip: Farmington, New Mexico 87401

Boardchair
E-Mail Address: hbdsk2@msn.com

Region: Northwest
Survey Date: May 3 - 7, 2010
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: Dan Maxwell, MS, Quality Management Bureau Chief/Health Care Surveyor, Division of Health Improvement/Quality Management Bureau; Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Barbara Czinger, MSW, LISW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Cathy Saxon, Regional Case Management Coordinator/Developmental Disability Support Division

Dear Ms. Pate,

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

Quality Management Approval Rating:

The Division of Health Improvement is issuing your agency a finding of "non compliance with conditions of participation" for basic compliance with DDSD Standards and regulations.

Plan of Correction:

The attached Report of Findings identifies deficiencies found during your agency's survey. You are required to complete and implement a Plan of Correction (POC). Please submit your agency's Plan of Correction (POC) in the



"Assuring safety and quality of care in New Mexico's health facilities and community-based programs."

David Rodriguez, 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>

space on the two right columns of the Report of Findings. See attachment A for additional guidance in completing the POC. The response is due to the parties below within 10 working days of the receipt of this letter:

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

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 working days. If your plan of correction is denied, you must resubmit a revised plan ASAP for approval. All remedies must still be completed within 45 working days of the original submission.

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

Request for Informal Reconsideration of Findings (IRF):

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

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

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

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

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

Please call the Team Leader at 505-231-7436, if you have questions about the survey or the report. 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: May 3, 2010

Present: **Excel Case Management Inc.**
Laura Pate, Executive Director

DOH/DHI/QMB

Tony Fragua, BFA, Team Lead/Healthcare Surveyor
Dan Maxwell, MS, Quality Management Bureau Chief/Healthcare Surveyor
Marti Madrid, LBSW, Healthcare Surveyor

DDSD - NW Regional Office

Cathy Saxton, Regional Case Management Coordinator

Exit Conference Date: May 5, 2010

Present: **Excel Case Management Inc.**
Laura Pate, Executive Director
Willetta Toledo, Case Manager
Shawn Jim, Case Manager
Tiffany Snipes, Case Manager

DOH/DHI/QMB

Tony Fragua, BFA, Team Lead/Healthcare Surveyor
Dan Maxwell, MS, Quality Management Bureau Chief/Healthcare Surveyor
Marti Madrid, LBSW, Healthcare Surveyor

DDSD - NW Regional Office

Cathy Saxton, Northwest Region Case Management Coordinator
Crystal Wright, Northwest Regional Director (via phone)
Dennis O'keefe, Northwest Region Community and Social Services Coordinator (via phone)

Administrative Locations Visited Number: 1

Total Sample Size Number: 23
6 - Jackson Class Members
17 - Non-Jackson Class Members

Case Manager Personnel Record Review: Number: 9

Case Managers Interviewed Number: 8

Records Reviewed (Persons Served) Number: 23

Administrative Files Reviewed

- Billing Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Quality Improvement/Quality Assurance Plan

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

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

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

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

Key to Scope scale:

Isolated:

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

Pattern:

A deficiency that impacts a number or group of individuals from 16% to 79% of the sample is defined as a pattern finding.

Pattern findings suggest the need for system wide corrective actions.

Widespread:

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

Key to Findings:

“Substantial Compliance”

“Compliance” indicates that a provider is in compliance with all ‘Conditions of Participation’ and substantial compliance with 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 be in “Compliance” the provider must not have any findings that are a Condition of Participation.

“Non Compliance”

“Substantial Compliance” also know as, “Partial Compliance” indicates a provider has obtained a minimum level of compliance, but still has isolated Conditions of Participation out of compliance. This isolated non-compliance if not corrected is a potential for more than minimal harm (scope/severity level “D”) to individuals’ health and safety. A provider in Substantial Compliance may have any number of “D” level Conditions of Participation out of compliance, but no Conditions higher than “D” level.

“Sub standard Compliance”

“Non-Compliance” indicates that a provider is out of compliance with one or more Conditions of Participation and/or other additional standards and regulations. This non-compliance if not corrected is a potential for more than minimal harm (scope/severity level “E” or “F”) to individuals’ health and safety.

Providers having repeat Non-compliance findings may be referred by QMB to the Internal Review Committee (IRC) for potential actions and sanctions, including but not limited to:

- Repeat findings of Conditions of Participation
- A pattern of repeat findings

Attachment C

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

Introduction:

Throughout the process, surveyors are openly communicating with providers. Open communication means that surveyors have clarified issues and/or requested missing information before completing the review. Regardless, there may still be instances where the provider disagrees with a specific finding.

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

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

The following limitations apply to the IRF process:

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

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

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

Administrative Review Process:

If a Provider desires to challenge the decision of the IRF committee they may request an Administrative Review by the DHI and DDS Director. The Request must be made in writing to the QMB Bureau Chief and received within 5 days of notification from the IRF decision.

Regarding IRC Sanctions:

The Informal Reconsideration of the Finding process is a separate process specific to QMB Survey Findings and should not be confused with any process associated with IRC Sanctions.

If a Provider desires to Dispute or Appeal an IRC Sanction that is a separate and different process. Providers may choose the Informal Dispute Resolution Process or the Formal Medicaid Fair Hearing Process to dispute or appeal IRC sanctions, please refer to the DOH Sanction policy and section 39 of the provider contract agreement.

Agency: Excel Case Management Inc. – Northwest Region
Program: Developmental Disabilities Waiver
Service: Case Management
Monitoring Type: Routine Survey
Date of Survey: May 3 – 7, 2010

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A03 CQI System	Scope and Severity Rating: C		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS</p> <p>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 leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both 	<p>Based on record review and interview, the Agency failed to establish and implement a Continuous Quality Management System regarding reviewing alleged complaints and incidents, as other requirements specifically required of Case Management and other DDW Providers.</p> <p>Review of the Agency's Quality Improvement Plan did not contain the following:</p> <ul style="list-style-type: none"> • 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. • A monitoring protocol that provides for the evaluation of quality, effectiveness and continued need for services and supports provided to the individual. • How the Agency will maintain regular communication with all providers delivering services and products to the individual. • Trends in achievement of individual outcomes in the Individual Service Plans; • Trends in medication and medical incidents leading to adverse health events; 		

- supervisory and direct support levels;
- (6) Quality and completeness documentation; and
- (7) Trends in individual and guardian satisfaction.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007

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

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

- A monitoring protocol that provides for the evaluation of quality, effectiveness and continued need for services and supports provided to the individual.
- Assure that reports and ISPs meet required timelines and include required content.
- Annual satisfaction surveys with individuals regarding case management services.
- How the Agency will maintain regular communication with all providers delivering services and products to the individual.

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

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

- Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;

When Surveyors were reviewing documentation specific to the Agency’s Internal Quality Improvement System, which included, a process for monitoring and reviewing evaluation of quality and effectiveness following was observed: :

- A written note found in the file, which was written by #49 stated: “I have no documentation that this has been reviewed.”

When #49 was asked if the Agency had an Incident Management Quality Improvement System, which included, a process for reviewing alleged, complaints & incident; documentation of internal investigations of alleged violations; reasonable steps taken to prevent further incident and documentation of corrective active, the following was reported:

- #49 stated, “I don’t have any trending reports or annual reports to give you. I have a Quality Improvement plan I just don’t do anything with it. I haven’t spent any quality time on looking into monitoring my case managers like I should be doing...We track external Incident Reports but we don’t monitor any trends formally.”

service provider shall provide the following internal monitoring and facilitating quality improvement system:

- (1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;
- (2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;
- (4) community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.

Tag # 1A08 Agency Case File	Scope and Severity Rating: C	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <ol style="list-style-type: none"> (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the 	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 22 of 23 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"> • ISP Assessment Checklist (#2, 12, 16 & 21) • ISP Signature Page <ul style="list-style-type: none"> ◦ Not Fully Constituted IDT (#8 & 9) • Addendum A (#1 & 20) (Individual #20, RORI filed, no plan of correction needed) • ISP Teaching & Support Strategies <ul style="list-style-type: none"> ◦ Individual #1 - TASS not found for: <ul style="list-style-type: none"> ➢ Will go to gym and exercise ➢ #1 will go swimming ◦ Individual #3 - TASS not found for: <ul style="list-style-type: none"> ➢ Purchase big bounce ➢ Jump on big bounce ➢ Resume duties at Warming Project ◦ Individual #7 - TASS not found for: <ul style="list-style-type: none"> ➢ Look for a job. ◦ Individual #12 - TASS not found for: <ul style="list-style-type: none"> ➢ Create schedule. ◦ Individual #13 - TASS not found for: <ul style="list-style-type: none"> ➢ Purchase CD at concert he attends ➢ Choose CD to listen to with staffs help/use remote ➢ Attend 4 fun food events ➢ Try new restaurant ➢ Staff research concerts in the area and purchase tickets 	

<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> <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 from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>	<ul style="list-style-type: none"> ◦ Individual #14 - TASS not found for: <ul style="list-style-type: none"> ➤ Travel in Four Corners Area ◦ Individual #18 - TASS not found for: <ul style="list-style-type: none"> ➤ Work schedule hours ➤ Plan over night trips ➤ Smoke one pack of cigarettes a day ➤ Swim one time a week ➤ Purchase gym membership ➤ Attend diabetic class ➤ Cook healthier meals ◦ Individual #19 - TASS not found for: <ul style="list-style-type: none"> ➤ Contact four centers to visit ➤ Visit centers ◦ Individual #21 - TASS not found for: <ul style="list-style-type: none"> ➤ Use scripts and Big Mac VOCA ➤ Different types of cause/effect manipulative ➤ Attend music events ➤ Add to music collection ◦ Individual #23 - TASS not found for: <ul style="list-style-type: none"> ➤ Obtain Job in security ➤ Keep Job • Positive Behavioral Plan (#18) • Positive Behavioral Crisis Plan (#18) • Speech Therapy Plan (#2 & 16) • Occupational Therapy Plan (#13) • Physical Therapy Plan (#1) • Health Assessment Tool (#5, 13 & 21) • Health Care Plans <ul style="list-style-type: none"> • Bowel <ul style="list-style-type: none"> ◦ Individual #4 - According to Agency Case File 		
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	<p>the individual is required to have a plan.</p> <ul style="list-style-type: none"> • Diabetes <ul style="list-style-type: none"> ◦ Individual #11 - According to Agency Case File the individual is required to have a plan. ◦ Individual #18 - According to Agency Case File the individual is required to have a plan. • General Health <ul style="list-style-type: none"> ◦ Individual #4 - According to Agency Case File the individual is required to have a plan. • GERD <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. ◦ Individual # 23- As indicated by the IST section of ISP the individual is required to have a plan. • Health Care Plans per ISP <ul style="list-style-type: none"> ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have Healthcare plans. ◦ Individual #16 - As indicated by the IST section of ISP the individual is required to have Healthcare plans. ◦ Individual #19 - As indicated by the IST section of ISP the individual is required to have Healthcare plans. • Hyperlipdemia <ul style="list-style-type: none"> ◦ Individual #11 - According to Agency Case File the individual is required to have a plan. • Mechanical Soft Diet <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. 		
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	<ul style="list-style-type: none"> • Nutrition <ul style="list-style-type: none"> ◦ Individual #4 – According to Agency Case File the Individual is required to have plan. • Problems with Communication <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Risk for Falls/ Unsteady Gait <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Skin Breakdown <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Seizures <ul style="list-style-type: none"> ◦ Individual #4 - According to Agency Case File the individual is required to have a plan. • Self Abuse <ul style="list-style-type: none"> ◦ Individual #4 - According to Agency Case File the individual is required to have a plan. • Total assist with Activities of Daily Living (ADL) <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Crisis Plans <ul style="list-style-type: none"> Allergies <ul style="list-style-type: none"> ◦ Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan. • Aspiration <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. ◦ Individual #21 - As indicated by the IST section of ISP the individual is required to have a plan. • Breathing 		
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	<ul style="list-style-type: none"> ◦ Individual #21- As indicated by the IST section of ISP the individual is required to have a plan. • Diabetes ◦ Individual #11 - As indicated by the IST section of ISP the individual is required to have a plan. • Fever ◦ Individual #21 - As indicated by the IST section of ISP the individual is required to have a plan. • G-Tube ◦ Individual #21 - As indicated by the IST section of ISP the individual is required to have a plan. • High Blood Pressure ◦ Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. • Hyperlipdemia ◦ Individual #11 - As indicated by the IST section of ISP the individual is required to have a plan. • Respiratory/Asthma ◦ Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. ◦ Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan. • Seizures ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. ◦ Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan. ◦ Individual #16 - As indicated by the IST section of ISP the individual is required to have a plan. ◦ Individual #19 - As indicated by the IST section 		
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	<p>of ISP the individual is required to have a plan.</p> <ul style="list-style-type: none"> ◦ Individual #21 - As indicated by the IST section of ISP the individual is required to have a plan. <ul style="list-style-type: none"> • Special Health Care Needs: <ul style="list-style-type: none"> • Meal Time Plan ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Nutritional Plan ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. • Loss of Vision Protocol ◦ Individual #13 - According to Agency Case File the individual is required to have a plan. • Dental Exam <ul style="list-style-type: none"> ◦ Individual #3 - As indicated by the documentation reviewed, exam was scheduled for 12/17/2008. Exam was cancelled. No evidence found to verify follow-up was completed. ◦ Individual #5 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #8 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #10 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #12 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. 		
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	<ul style="list-style-type: none"> ◦ Individual #22 - As indicated by the documentation reviewed, exam was completed on 11/20/2008. Follow-up was to be completed in 1 year. No evidence of follow-up found. • Auditory Exam <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the documentation reviewed, exam was completed on 12/28/2008. Follow-up was to be completed in 1 year. No evidence of follow-up found. ◦ Individual #8 - As indicated by the documentation reviewed, exam was completed on 12/04/2007. Follow-up was to be completed in 1 year. No evidence of follow-up found. ◦ Individual #18 - As indicated by the documentation reviewed, exam was completed on 11/28/2008. Follow-up was to be completed in 1 year. No evidence of follow-up found. • Vision Exam <ul style="list-style-type: none"> ◦ Individual #3 - As indicated by the documentation reviewed, exam was completed on 4/09/2009. Follow-up was to be completed in 1 year. No evidence of follow-up found. ◦ Individual #16 - As indicated by the documentation reviewed, exam was completed on 5/23/2007. Follow-up was to be completed in 1 year. No evidence of follow-up found. ◦ Individual #18 - As indicated by the documentation reviewed, exam was completed on 9/12/2008. Follow-up was to be completed in 1 year. No evidence of follow-up found. • Mammogram Exam <ul style="list-style-type: none"> ◦ Individual #9 - As indicated by the documentation reviewed, exam was completed on 6/04/2008. Follow-up was to be completed in 1 year. No evidence of follow-up found. 		
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	<ul style="list-style-type: none"> • Prostate Check <ul style="list-style-type: none"> ◦ Individual #13 - As indicated by the documentation reviewed, the exam was ordered on 2/18/2009. No evidence found to verify visit was completed. • Cholesterol, Blood Glucose & Blood Levels <ul style="list-style-type: none"> ◦ Individual #13 - As indicated by the documentation reviewed, lab work was ordered on 2/18/2009. No evidence found to verify it was completed. ◦ Individual #15 - As indicated by the documentation reviewed, lab work was ordered on 5/07/2008. Follow-up was to be completed in 1 year. No evidence of follow-up found. ◦ Individual #16 - As indicated by the documentation reviewed, lab work was ordered on 11/28/2007. Follow-up was to be completed in 6 months. No evidence of follow-up found. • Blood Levels <ul style="list-style-type: none"> ◦ Individual #10 - As indicated by the documentation reviewed, lab work was ordered on 1/21/2009. Follow-up was to be completed at 6 months & annually . No evidence of follow-up found. • Vocational Assessment Profile (#4 & 7) • Career Development Plan (#4 & 7) • Speech/Language Therapy Evaluation (#2 & 20) • Physical Therapy Evaluation (#1) • Guardianship Documentation (#5) • Transition Plan (#5) 		
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- IDT notes for 7/28/2009 meeting (#16)

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E		
<p>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p>	<p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 7 of 9 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #40 – Date of hire 2/02/2009 • #41 – Date of hire 7/08/2009 • #42 – Date of hire 12/06/2009 • #43 – Date of hire 3/02/2009 • #44 – Date of hire 2/02/2009 • #45 – Date of hire 2/18/2009 • #46 – Date of hire 4/14/2010 • #47 – Date of hire 6/12/2006 		

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

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

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007

Chapter 1.IV. General Provider Requirements.

D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: E		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>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 consumer, family member or legal guardian shall sign this at the time of orientation.</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 5 of 23 individuals.</p> <ul style="list-style-type: none"> • Parent/Guardian Incident Management Training - Abuse, Neglect & Misappropriation of Consumers' Property (#1, 2, 7, 11, 12, 16, 20 & 23) <ul style="list-style-type: none"> ○ Individual #1, 20 & 23 due diligence, no plan of correction required. 		

Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: B		
<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 5 of 23 individuals.</p> <ul style="list-style-type: none"> • Grievance/Complaint Procedure Acknowledgement (#1, 2, 7, 11, 12, 16, 20, & 23) <ul style="list-style-type: none"> ○ Individuals #1, 20 & 23 due diligence, no plan of correction required. 		

Tag #4C02 Scope of Services - Primary Freedom of Choice	Scope and Severity Rating: A		
<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 23 individuals.</p> <p>No evidence was found of the following:</p> <ul style="list-style-type: none"> • Primary Freedom of Choice (#16) 		

Tag # 4C04 (CoP) - Assessment Activities	Scope and Severity Rating: D		
<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> <ul style="list-style-type: none"> (a) LTCAA form (MAD 378); (b) Comprehensive Individual Assessment (CIA); (c) Current physical exam and medical/clinical history; (d) Norm-referenced adaptive behavioral assessment; and (e) A copy of the Allocation Letter (initial submission only). <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 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>	<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 23 individuals.</p> <p>The following items were not found and/or incomplete:</p> <ul style="list-style-type: none"> • Annual Physical (#8 & 10) 		

Tag # 4C05 (CoP) - Review & Approval of the LTCAA by NMMUR	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</p> <p>C. Review and Approval of the LTCAA by the New Mexico Medicaid Utilization Review (NMMUR) Agent</p> <p>(1) The Case Manager will submit the LTCAA packet to the NMMUR agent for review and approval. If it is an initial allocation, submission shall occur within 60 days from the date the DDS receives the individual's allocation letter for the DD Waiver. For re-determinations, submission shall occur between 45 days and 30 days prior to the ISP expiration date.</p> <p>(2) Prior to service delivery, the NMMUR agent shall approve:</p> <p>(a) All initial LTCAAs;</p> <p>(b) Any LTCAAs that result in a change in the level of care for the individual; and</p> <p>(c) Any re-admit LTCAAs to the DD Waiver.</p> <p>(3) In addition to initial allocations, the NMMUR agent reviews and approves the LTCAA every three years for individuals on the Waiver.</p> <p>(4) The Case Manager shall respond to NMMUR within specified timelines when the LTCAA packet is returned for corrections or additional information.</p>	<p>Based on record review, the Agency failed to maintain documentation of NMMUR review and approval of LTCAA for 1 of 23 individuals.</p> <p>The following items were not found, incomplete and/or not current:</p> <p>Re-Admit:</p> <ul style="list-style-type: none"> • Level of Care Individual #22 was hospitalized for 5 days. No evidence of re-admit found. 		

Tag #: 4C07 - Individual Service Planning & Approval	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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 guide the development of the plan.</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 4 of 23 Individuals. (#1, 2, 8 & 14)</p> <p>The following was found with regards to ISP Outcomes:</p> <ul style="list-style-type: none"> • Individual #1: "I will create a scrapbook of things I want to share". Outcome was does not indicate how and/or when it would be completed. • Individual #1: "I will work two times a week." Outcome was does not indicate how and/or when it would be completed. • Individual #1: "Add a wider variety of activities to daily schedule." Outcome was does not indicate how and/or when it would be completed. • Individual #1: "I will exercise" is to be completed 2 times per week; Swim 1 time per week. Outcome was does not indicate how and/or when it would be completed. • Individual #2: None found for the paid service of Community Access. No documentation was found indicating why the Individual did not an outcome for the area of Have Fun/Develop Relationship Vision. • Individual #8: "will do job developing with a job coach" is to be completed 2 times per month. Outcome was does not indicate how and/or when it would be completed. 		

	<ul style="list-style-type: none"> • Individual #8: “will learn how to download music on her laptop” is to be completed 1 time per week. Outcome was does not indicate how and/or when it would be completed. • Individual #8: “will create a display of her photos” is to be completed 1 time per month. Outcome was does not indicate how and/or when it would be completed. • Individual #8: “will go swimming” is to be completed 1 times per week. Outcome was does not indicate how and/or when it would be completed. • Individual #8: “will go to the gym” is to be completed 1 time per month. Outcome was does not indicate how and/or when it would be completed. • Individual #14: “will be a child entertainer through story and song.” Outcome was does not indicate how and/or when it would be completed. • Individual #14: “will become a member of the Fine Arts community” Outcome was does not indicate how and/or when it would be completed. • Individual #14: “will travel around the Four Corners, Albuquerque, and Colorado” is to be completed 2 times per month. Outcome was does not indicate how and/or when it would be completed. • Individual #14: “will watch a comedy” is to be completed 2 times per week. Outcome was does not indicate how and/or when it would be completed. 		
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| | <ul style="list-style-type: none">• Individual #14: “will purchase a comedy of her choice” is to be completed 1 time per week. Outcome was does not indicate how and/or when it would be completed. | | |
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Tag # 4C08 (CoP) - ISP Development Process	Scope and Severity Rating: E		
<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 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</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 5 of 23 individuals.</p> <p>Review of record found no evidence of the following:</p> <ul style="list-style-type: none"> • Rights & Responsibilities (#1, 2, 7, 11, 12, 16, 20 & 23) <ul style="list-style-type: none"> ○ Individuals #1, 20 & 23 due diligence, no plan of correction required • Case Manager Code of Ethics (#1, 2, 7, 11, 12, 16, 20 & 23) <ul style="list-style-type: none"> ○ Individuals #1, 20 & 23 due diligence, no plan of correction required. 		

not limited to the following:

- (a) Strengths;
- (b) Capabilities;
- (c) Preferences;
- (d) Desires;
- (e) Cultural values;
- (f) Relationships;
- (g) Resources;
- (h) Functional skills in the community;
- (i) Work interests and experiences;
- (j) Hobbies;
- (k) Community membership activities or interests;
- (l) Spiritual beliefs or interests; and
- (m) Communication and learning styles or preferences to be used in development of the individual's service plan.

(6) Case Managers shall operate under the presumption that all working age adults with developmental disabilities are capable of working given the appropriate supports. Individuals will be offered employment as a preferred day service over other day service options. It is the responsibility of the Case Manager and all IDT members to ensure that employment decisions are based on informed choices.

(a) The Case Manager shall verify that all Jackson Class members who express an interest in work or who have employment-related desired outcome(s) in the ISP have an initial or updated vocational assessment that has been completed within the preceding twelve (12) months.

(b) In cases when employment is not an immediate desired outcome, the ISP shall document the reasons for this decision and develop employment-related goals within the ISP that will be undertaken to explore employment options (e.g., volunteer activities, career exploration, situational assessments, etc.) This discussion related to employment issues shall be documented within the ISP or on the DDS

<p>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> <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	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</p> <p>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 2 of 23 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"> ◦ Community Access (#1) ◦ Speech Therapy (#3) 		

Tag # 4C12 (CoP) - Monitoring & Evaluation of Services	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</p> <p>J. Case Manager Monitoring and Evaluation of Service Delivery</p> <p>(1) The Case Manager shall use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual as specified in the ISP.</p> <p>(2) Monitoring and evaluation activities shall include, but not be limited to:</p> <p>(a) Face-To-Face Contact: A minimum of twelve (12) face-to-face contact visits annually (1 per month) is required to occur between the Case Manager and the individual served as described in the ISP; an exception is that children may receive a minimum of four visits per year;</p> <p>(b) Jackson Class members require two (2) face-to-face contacts per month, one of which occurs at a location in which the individual spends the majority of the day (i.e., place of employment, habilitation program) and one at the person's residence;</p> <p>(c) For non-Jackson Class members who receive Community Living Services, at least every other month, one of the face-to-face visits shall occur in the individual's residence;</p> <p>(d) For adults who are not Jackson Class 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>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 5 of 23 individuals.</p> <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 November 2009. ◦ Individual #5 – No Face to Face Visit Summary Forms found for August 2009. ◦ Individual #14 – No Face to Face Visit Summary Forms found for August 2009. ◦ Individual #19 – No Face to Face Visit Summary Forms found for April, June & August 2009. <p>Record review of Agency files found face-to-face visits were NOT ALTERNATING between Community Sites and Residence Sites as required by standard for the following individuals:</p> <p>Individual #7 (Non-Jackson)</p> <ul style="list-style-type: none"> • 3 Home Visits were noted between 3/2009 & 3/2010. All other visits took place at site visits ◦ 3/23/2009 – 10:30 – 11:30 am - Site Visit ◦ 4/9/2009 – 9 – 10am - Site Visit ◦ 5/11/2009 – 3:45 - 5:15 pm – Home 	

<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 DDS Regional Office and/or the Division of Health Improvement (DHI) as appropriate to the nature of the concern. Unless the nature of the concern is urgent, no more than fifteen (15) working days shall be allowed for remediation or development of an acceptable plan of remediation. This does not preclude the Case Managers' obligation to report abuse, neglect or exploitation as required by New Mexico Statute.</p> <p>(f) Service monitoring for children: When a parent chooses fewer than twelve (12) annual units of case management, the Case Manager will inform the parent of the parent's responsibility for the monitoring and evaluation activities during the months he or she does not receive case management services,</p> <p>(g) It is appropriate to conduct face-to-face visits with the individual both during the time the individual is receiving a service and during times the individual is not 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>	<ul style="list-style-type: none"> ◦ 6/2/2009 – 9:45 – 10:45 am - Site Visit ◦ 7/6/2009 – 12:15 – 1:15PM - Site Visit ◦ 8/10/2009 – 11:45 – 12:45PM - Site Visit ◦ 9/1/2009 – 8:30 – 9:30AM - Site Visit ◦ 10/17/2009 – 3:00 - 5:00PM – Home ◦ 11/3/2009 – 10 – 11AM - Site Visit ◦ 12/3/2009 - 9:45 – 12PM - ISP ◦ 1/26/2010 – 2 – 3PM - Site Visit ◦ 2/17/2010 – 9 – 10AM - Site Visit ◦ 3/18/2010 – 4:15-5:15 pm – Home 		
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(h) Communication with IDT members: Case Managers shall facilitate and maintain communication with the individual or his or her representative, other IDT members, providers and other relevant parties to ensure the individual receives maximum benefit of his or her services. Case Managers need to ensure that any needed adjustments to the service plan are made, where indicated. Concerns identified through communication with teams that are not remedied within a reasonable period of time shall be reported in writing to the respective regional office and/or the Division of Health Improvements, as appropriate to the concerns.

Tag # 4C15 - QA Requirements - Bi-Annual Reports & Provider Quarterly Reports	Scope and Severity Rating: B		
<p>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</p> <p>C. Quality Assurance Requirements: Case Management Provider Agencies will use an Internal Quality Assurance and Improvement Plan that must be submitted to and reviewed by the Statewide Case Management Coordinator, that shall include but is not limited to the following:</p> <p>(1) Case Management Provider Agencies are to:</p> <p>(a) Use a formal ongoing monitoring protocol that provides for the evaluation of quality, effectiveness and continued need for services and supports provided to the individual. This protocol shall be written and its implementation documented.</p> <p>(b) Assure that reports and ISPs meet required timelines and include required content.</p> <p>(c) Conduct a quarterly review of progress reports from service providers to verify that the individual's desired outcomes and action plans remain appropriate and realistic.</p> <p>(i) If the service providers' quarterly reports are not received by the Case Management Provider Agency within fourteen (14) days following the end of the quarter, the Case Management Provider Agency is to contact the service provider in writing requesting the report within one week from that date.</p> <p>(ii) If the quarterly report is not received within one week of the written request, the Case Management Provider Agency is to contact the respective DDS 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</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 16 of 23 individuals.</p> <p>The following quarterly/bi-annual reports were not found:</p> <ul style="list-style-type: none"> • Community Living Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #3 – None found for February 2009 – April 2009 & November 2009 – January 2010. • Supported Living Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #2 – None found for June 2009 – April 2010. ◦ Individual #9 – None found for April 2009 - August 2009 & January 2010 – March 2010. ◦ Individual #11 – None found for January 2010 – March 2010. ◦ Individual #13 – None found for October 2009 – March 2010. ◦ Individual #17 – None found for November 2009 – January 2010 ◦ Individual #21 – None found for April 2009 – March 2010. ◦ Individual #22 – None found for August 2009 – December 2009 • Supported Living Annual Assessment: <ul style="list-style-type: none"> ◦ Individual #22 – None found for January 2009 - January 2010. ◦ Individual #23 – None found for December 		

<p>the residence and at the Provider Agency of the Day Services for all individuals who have chronic medical condition(s) with potential for life threatening complications and/or who have behavioral challenge(s) that pose a potential for harm to themselves or others.</p> <p>(e) Assure at least quarterly that a current Health Care Plan (HCP) is in place in the residence and day service site for individuals who receive Community Living or Day Services and who have a HAT score of 4, 5, or 6. During face-to-face visits and review of quarterly reports, the Case Manager is required to verify that the Health Care Plan is being implemented.</p> <p>(f) Assure that Community Living Services are delivered in accordance with standards, including responsibility of the IDT Members to plan for at least 30 hours per week of planned activities outside the residence. If this is not possible due to the needs of the individual, a goal shall be developed that focuses on appropriate levels of community integration. These activities do not need to be limited to paid supports but may include independent or leisure activities appropriate to the individual.</p> <p>(g) Perform annual satisfaction surveys with individuals regarding case management services. A copy of the summary is due each December 10th to the respective DDSD Regional Office, along with a description of actions taken to address suggestions and problems identified in the survey.</p> <p>(h) Maintain regular communication with all providers delivering services and products to the individual.</p> <p>(i) Establish and implement a written grievance procedure.</p>	<p>2008 – December 2009.</p> <ul style="list-style-type: none"> • Family Living Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #4 – None found for November 2009 – January 2010. ◦ Individual #18 – None found for April 2009 – March 2010. • Family Living Annual Assessment: <ul style="list-style-type: none"> ◦ Individual #19 – None found for February 2009 - February 2010. • Community Inclusion - Adult Habilitation Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #3 – None found for November 2009 - April 2010. ◦ Individual #17 – None found for January 2010 – March 2010. ◦ Individual #18 – None found for April 2009 – March 2010. ◦ Individual #22 – None found for July 2009 – September 2009 & January 2010 – March 2010. • Community Inclusion - Community Access Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #2 – None found for June 2009 – April 2010. ◦ Individual #3 – None found for November 2009 - April 2010. ◦ Individual #11 – None found for July 2009 – September 2009. ◦ Individual #16 – None found for April 2009 – April 2010. 		
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<p>(j) Notify appropriate supervisory personnel within the Provider Agency if concerns are noted during monitoring or assessment activities related to any of the above requirements. If such concerns are not remedied by the Provider Agency within a reasonable mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office and/or DHI as appropriate to the nature of the concern. This does not preclude Case Managers' obligations to report abuse, neglect or exploitation as required by New Mexico Statute.</p> <p>(k) Utilize and submit the "Request for DDSD Regional Office Intervention" form as needed, such as when providers are not responsive in addressing a quality assurance concern. The Case Management Provider Agency is required to keep a copy in the individual's file.</p> <p>(2) Case Managers and Case Management Provider Agencies are required to promote and comply with the Case Management 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 #17 – None found for January 2010 – March 2010. ◦ Individual #18 – None found for April 2009 – March 2010. ◦ Individual #22 – None found for July 2009 – September 2009 & January 2010 – March 2010. <p>• Community Access Annual Assessment:</p> <ul style="list-style-type: none"> ◦ Individual #3 – None found for February - February 2010. <p>• Community Inclusion - Supported Employment Quarterly Reports:</p> <ul style="list-style-type: none"> ◦ Individual #18 – None found for April 2009 – March 2010. <p>• Speech & Language Pathology Bi-Annual Progress Reports:</p> <ul style="list-style-type: none"> ◦ Individual #2 – None found for September 2008 – September 2009. ◦ Individual #16 – None found for March 2009 – March 2010. ◦ Individual #20 – None found for February 2009 – February 2010. ◦ Individual #21 – None found for June 2009 – December 2009. <p>• Occupational Bi-Annual Progress Reports:</p> <ul style="list-style-type: none"> ◦ Individual #20 – None found for June 2009 – December 2009. <p>• Physical Bi-Annual Progress Reports:</p> <ul style="list-style-type: none"> ◦ Individual #1 – None found for June 2009 – 		
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	<p>November 2009.</p> <ul style="list-style-type: none">• Quarterly Nursing Report:<ul style="list-style-type: none">◦ Individual #1 – None found for July 2009 – April 2010.◦ Individual #4 – None found for November 2009 – January 2010.◦ Individual #8 – None found for April 2009 – April 2010.◦ Individual #11 – None found for April 2009 – March 2010.◦ Individual #16 – None found for April 2009 – April 2010◦ Individual #21 – None found for April 2009 – April 2010.		
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Tag # 4C20 (CoP) - Supervision Req.	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</p> <p>H. Case Management Provider Agency Supervision Requirements</p> <p>(1) Provider Agencies shall implement written procedures for training, supervision and corrective action for Case Management staff and/or subcontractors. Documentation of above needs to be maintained in personnel files.</p> <p>(2) Individuals providing supervision/oversight must have at least two (2) years as experienced Case Managers for individuals with developmental disabilities and must meet all qualifications for Case Managers under Section IV, E, (1). Case management supervisors who also carry a caseload may not perform quality assurance reviews on their own work.</p> <p>(3) Contract performance management procedures equivalent to employee supervision procedures shall be carried out for Case Management sub-contractors.</p> <p>(4) Provider Agencies shall monitor and oversee the eligibility process for new allocations and for re-determinations.</p> <p>(5) On a quarterly basis, Provider Agencies are required to mentor and monitor service planning and ISP development by Case Managers, including a quality assurance review of a sample of ISPs written by each Case Manager. For Jackson Class members, all ISPs are required to be reviewed; for non-</p>	<p>Based on record review, the agency failed to implement written procedures for training, supervision and corrective action for Case Management staff and/or Subcontractors.</p> <p>During the on-site week of May 3 - 5, 2010 a copy of the agency's policy and procedure regarding case management training, supervision and correction action for Case Management staff and/or subcontractors was requested. The information provided by the Agency of the Agency's policy and procedures did not contain:</p> <p>(6) Provider Agencies are required to evaluate the quality of monitoring conducted by Case Managers with regard to ISP implementation and health and safety for individuals served, including timely medical intervention to follow-up on recommendations by medical and/or clinical practitioners.</p> <p>(7) Provider Agencies shall oversee Quality Assurance and Improvement Requirements for Case Managers.</p> <p>(9) Provider Agencies are required to assure all records include current provider quarterly reports and that each record is complete in adherence with DDS policies, procedures and standards.</p> <p>(10) Provider Agencies must assure adherence to timelines set forth by DDS.</p>		

<p>Jackson Class members, a ten percent (10%) sample is required. Copies of all critiqued ISPs, both Jackson and non-Jackson samples, shall be submitted to the respective DDSD Regional Office.</p> <p>(6) Provider Agencies are required to evaluate the quality of monitoring conducted by Case Managers with regard to ISP implementation and health and safety for individuals served, including timely medical intervention to follow-up on recommendations by medical and/or clinical practitioners.</p> <p>(7) Provider Agencies shall oversee Quality Assurance and Improvement Requirements for Case Managers.</p> <p>(8) Provider Agencies shall assure Case Manager compliance with training requirements.</p> <p>(9) Provider Agencies are required to assure all records include current provider quarterly reports and that each record is complete in adherence with DDSD policies, procedures and standards.</p> <p>(10) Provider Agencies must assure adherence to timelines set forth by DDSD.</p>			
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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 23 of 23 individuals. Progress notes and billing records supported billing activities for the months of January, February and March 2010.