

Date: December 1, 2010

To: Sherri Binkley, Owner/Director
Provider: Peak Developmental Services, Inc.
Address: 3500 Comanche NE, Bldg. C
State/Zip: Albuquerque, NM 87107

Email Address: peakcm@aol.com

Region: Southwest & Southeast
Survey Date: October 4 – 6, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Case Management
Survey Type: Routine
Team Leader: Deb Russell, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Valerie V. Valdez, Healthcare Program Manager/Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Cheryl Dunfee, Case Management Coordinator, Developmental Disabilities Support Division/Southwest Regional Office

Dear Ms. Binkley;

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**

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



“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 – Peak Case Management – Southwest & Southeast Region – October 4 - 6, 2010

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,

Deb Russell, BS

Deb Russell, BS
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: October 4, 2010

Present: **Peak Developmental Services, Inc.**
Marie Almanzar, Case Manager

DOH/DHI/QMB

Deb Russell, BS, Team Lead/Healthcare Surveyor
Valerie V. Valdez, MS, Healthcare Program Manager/ Healthcare Surveyor

DDSD - Southwest Regional Office

Cheryl Dunfee, BSW, Case Management Coordinator

Exit Conference Date: October 6, 2010

Present: **Peak Developmental Services, Inc.**
Sherri Binkley, Owner/Director
Sarah Heartsong, Case Manager Supervisor

DOH/DHI/QMB

Deb Russell, BS, Team Lead/Healthcare Surveyor

DDSD - Southwest Regional Office

Cheryl Dunfee, BSW, Case Management Coordinator

Administrative Locations Visited Number: 1

Total Sample Size Number: 24
3 - *Jackson Class Members*
21 - *Non-Jackson Class Members*

Case Managers Interviewed Number: 7

Records Reviewed (Persons Served) Number: 25

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 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
 - 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 DDSD 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: Peak Developmental Services, Inc. - Southwest & Southeast Regions
Program: Developmental Disabilities Waiver
Service: Case Management
Monitoring Type: Routine Survey
Date of Survey: October 4 – 6, 2010

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A08 Agency Case File	Scope and Severity Rating: B		
<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> <p>(1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;</p> <p>(2) The individual's complete and current ISP, with all supplemental plans specific to the individual,</p>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 9 of 24 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Did not contain Health Plan Information (#5 & 13) ◦ Did not contain Physician's Telephone Number (#15) • ISP Assessment Checklist (#5, 12, 13 & 25) • ISP Signature Page <ul style="list-style-type: none"> ◦ None Found (#15) • ISP Teaching & Support Strategies <ul style="list-style-type: none"> ◦ Individual #4 - TASS not found for: <ul style="list-style-type: none"> ➢ Practice recognizing street signs ➢ Say action of street sign ➢ Recognize 6 street signs ◦ Outcome Statement #3 <ul style="list-style-type: none"> ➢ Print out pictures ◦ Individual #5 - TASS not found for: 		

<p>and the most current completed Health Assessment Tool (HAT);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>	<ul style="list-style-type: none"> ◦ Outcome Statement #1 <ul style="list-style-type: none"> ➤ Will be presented with 2 choices of new pastime activity. ◦ Individual #12 - TASS not found for: ◦ Outcome Statement #1 <ul style="list-style-type: none"> ➤ Pick plants ➤ Weed foliage ➤ Water foliage ◦ Outcome Statement #2 <ul style="list-style-type: none"> ➤ Practice reading skills ◦ Outcome Statement #3 <ul style="list-style-type: none"> ➤ Choose days to attend senior center community ➤ Schedule transportation ◦ Individual #13 - TASS not found for: ◦ Outcome Statement #1 <ul style="list-style-type: none"> ➤ Pick what meal to prepare ➤ Write a grocery list ➤ Go to the grocery store ➤ Read her step by step cards ➤ Prepare her meal ◦ Outcome Statement #2 <ul style="list-style-type: none"> ➤ Practice using her computer ◦ Outcome Statement #3 <ul style="list-style-type: none"> ➤ Choose recipes of her choice ◦ Individual #17 - TASS not found for: ◦ Outcome Statement #1 <ul style="list-style-type: none"> ➤ Hold an object presented to him ◦ Outcome Statement #2 <ul style="list-style-type: none"> ➤ Increase range of motion by riding his bike ◦ Outcome Statement #3 <ul style="list-style-type: none"> ➤ Select a place of his choice 		
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	<ul style="list-style-type: none"> ◦ Individual #25 - TASS not found for: ◦ Outcome Statement #1 <ul style="list-style-type: none"> ➤ Explore other financing options and/or available options to become a home owner ◦ Outcome Statement #3 <ul style="list-style-type: none"> ➤ Take an airplane trip to the destination of his choice ◦ Outcome Statement #4 <ul style="list-style-type: none"> ➤ Create at least 6 art projects to use in decorating his home and/or work place • Positive Behavioral Crisis Plan (#25) • Speech Therapy Plan (#5) • Health Assessment Tool (#12) • Health Care Plans <ul style="list-style-type: none"> • HAT score level 4 <ul style="list-style-type: none"> ◦ Individual #25 - As indicated by the HAT Score the individual is required to have a plan. • HAT score level 5 <ul style="list-style-type: none"> ◦ Individual #5 - As indicated by the HAT Score the individual is required to have a plan. • Crisis Plans <ul style="list-style-type: none"> • Cardiac Condition <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. • Allergies <ul style="list-style-type: none"> ◦ Individual #4 - 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. • Asthma <ul style="list-style-type: none"> ◦ Individual #5 - According to the Level of Care 		
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	<p>the individual is required to have a plan.</p> <ul style="list-style-type: none"> • Seizures <ul style="list-style-type: none"> ◦ Individual #22 – As indicated by the IST section of the ISP the individual is required to have a plan. <p>Other Individual Specific Evaluations & Examinations:</p> <ul style="list-style-type: none"> • Dental Exam <ul style="list-style-type: none"> ◦ Individual #5 – 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. ◦ Individual #13 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #15 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. Last dental visit found was 6/2/2009. • Vocational Assessment Profile (#12) • Career Development Plan (#12) • Speech/Language Therapy Evaluation (#2, 5 & 22) 		
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Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: D		
<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>E. Documentation for other staff. With</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 1 of 10 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"> • #42 – Date of hire 8/1/2008. Completed on 8/18/2008. 		

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 #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 24 individuals.</p> <p>No evidence was found of the following:</p> <ul style="list-style-type: none"> • Primary Freedom of Choice (#5) 		

Tag # 4C07 - Individual Service Planning	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>7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF</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 8 of 24 Individuals.</p> <p>The following was found with regards to ISP Outcomes:</p> <ul style="list-style-type: none"> • Individual #5: <ul style="list-style-type: none"> ◦ Increase socialization exposure to recreational & community activities. Outcome was does not indicate how and/or when it would be completed. • Individual #9: <ul style="list-style-type: none"> ◦ Try new recipes she finds enjoyable. Outcome was does not indicate how and/or when it would be completed. ◦ Participate in camera club. Outcome was does not indicate how and/or when it would be completed. • Individual #11: <ul style="list-style-type: none"> ◦ Maintain weight and hypertension by exercise. Outcome was does not indicate how and/or when it would be completed. • Individual #12: <ul style="list-style-type: none"> ◦ Attend the gym is to be completed 2 times per week. Outcome was does not indicate how and/or when it would be completed. • Individual #14: <ul style="list-style-type: none"> ◦ Be a good "mom" to my pets. Outcome does not indicate how and/or when it would be completed. 		

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.

- Individual #15:
 - Explore new activities in the community. Outcome does not indicate how and/or when it would be completed.
- Individual #17:
 - Hold an object on his hand for 2 to 5 seconds. Outcome does not indicate how and/or when it would be completed.
 - Will ride his bike for 10 to 15 minutes daily. Outcome does not indicate how and/or when it would be completed.
- Individual #23:
 - Is a responsible dog owner. Outcome does not indicate how and/or when it would be completed.

Tag # 4C09 - Secondary FOC	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>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 5 of 24 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"> ◦ Supported Living (#25) ◦ Family Living (#5) ◦ Adult Habilitation (#12 & 13) ◦ Community Access (#17) ◦ Supported Employment (#25) ◦ Speech Therapy (#5 & 25) ◦ Goods & Services (#5 & 12) ◦ Respite (#5) 		

Tag # 4C12 (CoP) - Monitoring & Evaluation of Services	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>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 4 of 24 individuals.</p> <p>Record review of Agency files found NO evidence of Case Manager Monthly Case Notes for the following:</p> <ul style="list-style-type: none"> • Individual #4 - None found for 7/2010 & 8/2010 • Individual #5 - None found for 7/2010 & 8/2010 <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 #4 – No Face to Face Visit Summary Forms found for 7/2010 & 8/2010. ◦ Individual #5 – No Face to Face Visit Summary Forms found for 7/2010 & 8/2010. <p>Record review of Agency files found face-to-face visits were NOT being completed as required by standard (2 b, c & d) for the following individuals:</p> <p>Individual #16 (Jackson)</p> <ul style="list-style-type: none"> • No site visit was noted 6/2010 <p>Individual #23 (Non-Jackson)</p> <ul style="list-style-type: none"> • 2 home visits were noted between 1/2010 & 8/2010. The individual receives Family Living Services. <ul style="list-style-type: none"> ◦ 1/29/2010 – 5:00 pm – Mall ◦ 2/12/2010 – 4:30 pm – Mall 		

<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"> ◦ 3/25/2010 – 10:00 am – Community ◦ 4/16/2010 – 5:00 pm – Home ◦ 5/6/2010 – 11:30 am – Community ◦ 6/9/2010 – 4:30 pm – Community ◦ 7/1/2010 – 4:00 pm – Case Management Agency ◦ 8/14/2010 – 4:00 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 # 4C15.1 - QA Requirements - Bi-Annual Reports & Provider Quarterly Reports	Scope and Severity Rating: A		
<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 4 of 24 individuals.</p> <p>The following quarterly/bi-annual reports were not found:</p> <ul style="list-style-type: none"> • Family Living Quarterly/Monthly Reports: <ul style="list-style-type: none"> ◦ Individual #4 – None found for 4/2010 – 6/2010 & 8/2010. ◦ Individual #5 – None found for 2/2010, 5/2010 & 8/2010. • Family Living Annual Assessment <ul style="list-style-type: none"> ◦ Individual #4 – None found for 6/2009 – 6/2010. ◦ Individual #17 – None found for 6/2009 – 6/2010. • Community Inclusion - Adult Habilitation Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #4 – None found for 7/2009 – 9/2009. ◦ Individual #5 – None found for 7/2009 – 9/2009 & 4/2010 – 6/2010. ◦ Individual #12 – None found for 11/2009 – 7/2010. • Community Inclusion - Community Access Quarterly Reports: <ul style="list-style-type: none"> ◦ Individual #12 – None found for 11/2009 – 7/2010. ◦ Individual #17 – None found for 12/2009 – 6/2010. 		

<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>	<ul style="list-style-type: none"> ● Occupational Bi-Annual Progress Reports: <ul style="list-style-type: none"> ◦ Individual #12 – None found for 8/2009 – 2/2010. ● Quarterly Nursing Reports: <ul style="list-style-type: none"> ◦ Individual #5 – None found for 11/2009 – 7/2010. Individual #5 has a HAT score level 5. ◦ Individual #17 – None found for 6/2009 – 6/2010. Individual #17 has a HAT score level 4. 		
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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>			
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