

Date: August 1, 2019

To: Anthony L. Ross, Executive Director
Provider: Amigo Case Management, Inc.
Address: 10515 4th Street NW
City, State, Zip: Albuquerque, New Mexico 87114

E-mail Address: acm2130@aol.com

Board Secretary: Cristy J. Carbon-Gaul
E-Mail Address: cristy@carbon-gaul.com

Region: Metro
Survey Date: June 21 - 27, 2019
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2018: Case Management**

Survey Type: Routine

Team Leader: Elisa Alford, MSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Member: Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Crystal Lopez-Beck, BA, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau; Kayla Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Heather Driscoll, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Wolf Krusemark, BFA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Anthony L. Ross;

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Determination of Compliance:

The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags: This determination is based on noncompliance with one to five (1 – 5) Condition of Participation Level Tags (*refer to Attachment D for*

DIVISION OF HEALTH IMPROVEMENT
5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
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QMB Report of Findings – Amigo Case Management, Inc. – Metro – June 21 - 27, 2019

details). The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 4C07 Individual Service Planning (Visions, measurable outcomes, action steps)
- Tag # 4C12 Monitoring and Evaluation of Services
- Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)
- Tag # 1A22/4C02 Case Manager - Individual Specific Competencies

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File
- Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components
- Tag # 1A08.4 Assistive Technology Inventory List
- Tag # 4C02 Scope of Services - Primary Freedom of Choice
- Tag # 4C08 ISP Development Process
- Tag # 4C09 Secondary FOC
- Tag #4C10 Apprv. Budget Worksheet Waiver Review Form
- Tag # 4C15.1 Service Monitoring - Annual / Semi-Annual Reports & Provider Semi - Annual / Quarterly Reports
- Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)
- Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)
- Tag # 1A15.2 Administrative Case File - Healthcare Documentation (Therap and Required Plans)
- Tag # 1A29 Complaints / Grievances – Acknowledgement
- Tag # 4C21 Case Management Reimbursement

Plan of Correction:

The attached Report of Findings identifies the deficiencies found during your agency's on-site compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (Attachment A) for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

Corrective Action for Current Citation:

- How is the deficiency going to be corrected? (i.e. obtained documents, retrain staff, individuals and/or staff no longer in service, void/adjusts completed, etc.) This can be specific to each deficiency cited or if possible an overall correction, i.e. all documents will be requested and filed as appropriate.

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done on an ongoing basis? (i.e. file reviews, etc.)
- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position within your agency)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction in the available space on the two right-hand columns of the Report of Findings. (See attachment "A" for additional guidance in completing the Plan of Correction).

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

1. **Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator
1170 North Solano Suite D Las Cruces, New Mexico 88001**
2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

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

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Billing Deficiencies:

If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a "Void/Adjust" claim or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: *Lisa Medina-Lujan*
HSD/OIG/Program Integrity Unit
1474 Rodeo Road
Santa Fe, New Mexico 87505

If you have questions and would like to speak with someone at HSD/OIG/PIU, please contact:

Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)
OR
Jennifer Goble (Jennifer.goble2@state.nm.us)

Please be advised that there is a one-week lag period for applying payments received by check to Void/Adjust claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

Request for Informal Reconsideration of Findings (IRF):

If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

Request for Informal Reconsideration of Findings
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request/QMB

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator Amanda Castaneda at 575-373-5716 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,

Elisa Alford, MSW

Elisa Alford, MSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date: June 21, 2019

Contact: **Amigo Case Management, Inc.**
Tony Ross, Executive Director

DOH/DHI/QMB
Elisa C. Perez Alford, MSW, Team Lead/Healthcare Surveyor

On-site Entrance Conference Date: June 23, 2019

Present: **Amigo Case Management, Inc.**
Tony Ross, Executive Director
Claudia de la Cruz, Case Manager
Kalynn Jaramillo, Case Manager
Jena Pappas, Case Manager
Nikki Kutulas, Case Manager
Janet Espinosa, Administrative Assistant

DOH/DHI/QMB
Elisa Alford, MSW, Team Lead/Healthcare Surveyor
Crystal Lopez-Beck, BA, Deputy Bureau Chief
Lora Norby, Healthcare Surveyor
Wolf Krusemark, BFA, Healthcare Surveyor Supervisor
Roxanne Garcia, BA, Healthcare Surveyor

Exit Conference Date: June 27, 2019

Present: **Amigo Case Management Inc.**
Tony Ross, Executive Director
Claudia de la Cruz, Case Manager
Jena Pappas, Case Manager
Nikki Kutulas, Case Manager

DOH/DHI/QMB
Elisa Alford, MSW, Team Lead/Healthcare Surveyor
Crystal Lopez-Beck, BA, Deputy Bureau Chief
Kayla Benally, BSW, Healthcare Surveyor
Heather Driscoll, AA, Healthcare Surveyor

DDSD – Metro Regional Office
Ellen Hardman, Case Management Coordinator

Administrative Locations Visited 1

Total Sample Size 30
2 - *Jackson* Class Members
28 - *Non-Jackson* Class Members

Persons Served Records Reviewed 30

Case Manager Interviewed 9

Case Manager Records Reviewed 9

Total # of Secondary Freedom of Choices 134

Administrative Interviews 2

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
 - Individual Service Plans
 - Progress on Identified Outcomes
 - Healthcare Plans
 - Medication Administration Records
 - Medical Emergency Response Plans
 - Therapy Evaluations and Plans
 - Healthcare Documentation Regarding Appointments and Required Follow-Up
 - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- 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
NM Attorney General's Office

Attachment A

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

Introduction:

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

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

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

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment C).

Instructions for Completing Agency POC:

Required Content

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice cited to prevent recurrence and information that ensures the regulation cited comes into and remains in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance (QA) Plan.

If a deficiency has already been corrected since the on-site survey, 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 following details should be considered when developing your Plan of Correction:

The Plan of Correction must address each deficiency cited in the Report of Findings unless otherwise noted with a "No Plan of Correction Required statement." The Plan of Correction must address the five (5) areas listed below:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

The following details should be considered when developing your Plan of Correction:

- Details about how and when Individual Served, agency personnel and administrative and service delivery site files are audited by agency personnel to ensure they contain required documents;
- Information about how medication administration records are reviewed to verify they contain all required information before they are distributed to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (LOC) packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

Note: Instruction or in-service of staff alone may not be a sufficient plan of correction. This is a good first step toward correction, but additional steps must be taken to ensure the deficiency is corrected and will not recur.

Completion Dates

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
 - a. Electronically at AmandaE.Castaneda@state.nm.us (**preferred method**)
 - b. Fax to 575-528-5019, or
 - c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001
5. **Do not submit supporting documentation** (evidence of compliance) to QMB **until after** your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”
 - a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45-business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
 - b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.
 - c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
 - d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
 - e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

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

1. Your internal documents are due within a *maximum* of 45-business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If documents containing HIPAA Protected Health Information (PHI) documents must be submitted through S-Comm (Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to e-mails.
3. All submitted documents *must be annotated*; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

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, 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.

Attachment B

Department of Health, Division of Health Improvement QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and other state and federal regulations. For the purpose of the case management survey the CMS waiver assurances have been grouped into five (5) Service Domains: Plan of Care (Development and Monitoring); Level of Care; Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Assurance system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

Service Domains and CoPs for Case Management are as follows:

Service Domain: Plan of Care ISP Development & Monitoring - *Service plans address all participants' assessed needs (including health and safety risk factors) and goals, either by waiver services or through other means. Services plans are updated or revised at least annually or when warranted by changes in the waiver participants' needs.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.3** – Administrative Case File - Individual Service Plan (ISP) / ISP Components
- **4C07** – Individual Service Planning (Visions, measurable outcome, action steps)
- **4C07.1** – Individual Service Planning – Paid Services
- **4C10** – Apprv. Budget Worksheet Waiver Review Form / MAD 046
- **4C12** – Monitoring & Evaluation of Services
- **4C16** – Requirements for Reports & Distribution of ISP (Provider Agencies, Individual and/or Guardian)

Service Domain: Level of Care - *Initial and annual Level of Care (LOC) evaluations are completed within timeframes specified by the State.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **4C04** – Assessment Activities

Service Domain: Qualified Providers - *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A22/4C02** – Case Manager: Individual Specific Competencies

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):

- **1A25.1** – Caregiver Criminal History Screening
- **1A26.1** – Consolidated On-line Registry Employee Abuse Registry

Service Domain: Health, Welfare and Safety - *The State, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.2** – Administrative Case File: Healthcare Requirements & Follow-up
- **1A15.2** – Administrative Case File: Healthcare Documentation (Therap and Required Plans)

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):

- **1A05** – General Requirements

Attachment C

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

Introduction:

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

Instructions:

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

The following limitations apply to the IRF process:

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process.

Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status. If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.

QMB Determinations of Compliance

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of *Compliance*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

Partial-Compliance with Standard Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags* indicates that a provider is in compliance with all Condition of Participation Level deficiencies but is out of compliance with a certain percentage of Standard Level deficiencies. This partial-compliance, if not corrected, may result in a negative outcome or the potential for more than minimal harm to individuals' health and safety. There are two ways to receive a determination of Partial Compliance with Standard Level Tags:

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.
2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety.

Non-Compliance:

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 17 or more Standard Level Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any tag.
2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Standard Level Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
CoP Level Tags:	0 CoP	0 CoP	0 CoP	0 CoP	1 to 5 CoPs	0 to 5 CoPs	6 or more CoPs
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
"Non-Compliance"						17 or more Standard Level Tags with 75 to 100% of the Individuals in the sample cited in any tag.	Any Amount of Standard Level Tags and 6 or more Conditions of Participation Level Tags.
"Partial Compliance with Standard Level tags and Condition of Participation Level Tags"					Any Amount of Standard Level Tags, plus 1 to 5 Conditions of Participation Level tags.		
"Partial Compliance with Standard Level tags"			up to 16 Standard Level Tags with 75 to 100% of the individuals in the sample cited in any tag.	17 or more Standard Level Tags with 50 to 74% of the individuals in the sample cited any tag.			
"Compliance"	Up to 16 Standard Level Tags with 0 to 74% of the individuals in the sample cited in any tag.	17 or more Standard Level Tags with 0 to 49% of the individuals in the sample cited in any tag.					

Agency: Amigo Case Management Inc. - Metro
Program: Developmental Disabilities Waiver
Service: 2018: Case Management
Survey Type: Routine
Survey Date: June 21 - 27, 2019

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>Service Domain: Plan of Care - ISP Development & Monitoring - Service plans address all participants' assessed needs (including health and safety risk factors) and goals, either by waiver services or through other means. Services plans are updated or revised at least annually or when warranted by changes in the waiver participants' needs.</p>			
<p>Tag # 1A08 Administrative Case File</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record: The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix.</p> <p>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.</p>	<p>Standard Level Deficiency</p> <p>Based on record review, the Agency did not maintain a complete client record at the administrative office for 5 of 30 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p>Individual Data Form:</p> <ul style="list-style-type: none"> • Did not contain Individual's assistive technology and/or adaptive equipment (#4, 9) • Did not contain Individual's allergies (#4, 11, 12) • Did not contain Individual's insurance information (#9) • Did not contain Individual's guardianship information (#9, 11, 12) • Did not contain emergency contact information (#30) • Did not contain Individual's information on advanced directives (#9, 11) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

<p>2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable.</p> <p>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</p> <p>5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p>20.5.1 Individual Data Form (IDF): The Individual Data Form provides an overview of demographic information as well as other key personal, programmatic, insurance, and health related information. It lists medical information; assistive technology or adaptive equipment; diagnoses; allergies; information about whether a guardian or advance directives are in place; information about behavioral and health related needs; contacts of Provider Agencies and team</p>	<ul style="list-style-type: none"> • Did not contain Individual's behavioral and health needs (#9) • Did not contain contact information for provider agencies and team members (#9, 11,12, 30) • Did not contain Individual's medical information/diagnoses (#12) 		
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<p>members and other critical information. The IDF automatically loads information into other fields and forms and must be complete and kept current. This form is initiated by the CM. It must be opened and continuously updated by Living Supports, CCS- Group, ANS, CIHS and case management when applicable to the person in order for accurate data to auto populate other documents like the Health Passport and Physician Consultation Form. Although the Primary Provider Agency is ultimately responsible for keeping this form current, each provider collaborates and communicates critical information to update this form.</p> <p>Chapter 3 Safeguards 3.1.2 Team Justification Process: DD Waiver participants may receive evaluations or reviews conducted by a variety of professionals or clinicians. These evaluations or reviews typically include recommendations or suggestions for the person/guardian or the team to consider. The team justification process includes:</p> <ol style="list-style-type: none"> 1. Discussion and decisions about non-health related recommendations are documented on the Team Justification form. 2. The Team Justification form documents that the person/guardian or team has considered the recommendations and has decided: <ol style="list-style-type: none"> a. to implement the recommendation; b. to create an action plan and revise the ISP, if necessary; or c. not to implement the recommendation currently. 3. All DD Waiver Provider Agencies participate in information gathering, IDT meeting attendance, and accessing supplemental resources if needed and desired. 4. The CM ensures that the Team Justification Process is followed and complete. 			
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<p>templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e. an acknowledgement of receipt of specific information) and other elements depending on the age of the individual. The ISP templates may be revised and reissued by DDS to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDS and be required for use in order to better demonstrate required elements of the PCP process and ISP development.</p> <p>The ISP is completed by the CM with the IDT input and must be completed according to the following requirements:</p> <ol style="list-style-type: none"> 1. DD Waiver Provider Agencies should not recommend service type, frequency, and amount (except for required case management services) on an individual budget prior to the Vision Statement and Desired Outcomes being developed. 2. The person does not require IDT agreement/approval regarding his/her dreams, aspirations, and desired long-term outcomes. 3. When there is disagreement, the IDT is required to plan and resolve conflicts in a manner that promotes health, safety, and quality of life through consensus. Consensus means a state of general agreement that allows members to support the proposal, at least on a trial basis. 4. A signature page and/or documentation of participation by phone must be completed. 5. The CM must review a current Addendum A and DHI ANE letter with the person and Court appointed guardian or parents of a minor, if applicable. <p>6.7 Completion and Distribution of the ISP: The CM is required to assure all elements of the ISP</p>			
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and companion documents are completed and distributed to the IDT...

Chapter 20: Provider Documentation and Client Records 20.2 Client Records

Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.

Tag # 1A08.4 Assistive Technology Inventory List	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record: The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix.</p> <p>Chapter 12: Professional and Clinical Services Therapy Services: 12.4.7.3 Assistive Technology (AT) Services, Personal Support Technology (PST) and Environmental Modifications: Therapists support the person to access and utilize AT, PST and Environmental Modifications through the following requirements: 2. Therapist are required to maintain a current AT Inventory in each Living Supports and CCS site where AT is used, for each person using AT related to that therapist's scope of service. 3. Therapists are required to initiate or update the AT Inventory annually, by the 190th day following the person's ISP effective date, so that it accurately identifies the assistive technology currently in use by the individual and related to that therapist's scope of service.</p> <p>Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.</p>	<p>Based on record review, the Agency did not maintain a complete client record at the administrative office for 2 of 30 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p>Assistive Technology Inventory List:</p> <ul style="list-style-type: none"> • Individual #4 - As indicated by the Health and Safety section of ISP the individual is required to have an inventory list. No evidence of inventory found. • Individual #9 - As indicated by the Health and Safety section of ISP the individual is required to have an inventory list. No evidence of inventory found. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	<p> </p>

Tag # 4C07 Individual Service Planning (Visions, measurable outcomes, action steps)	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 4: Person-Centered Planning (PCP): 4.1 Essential Elements of Person-Centered Planning (PCP): Person-centered planning is a process that places a person at the center of planning his/her life and supports. It is an ongoing process that is the foundation for all aspects of the DD Waiver Program and DD Waiver Provider Agencies' work with people with I/DD. The process is designed to identify the strengths, capacities, preferences, and needs of the person. The process may include other people chosen by the person, who are able to serve as important contributors to the process. Overall, PCP involves person-centered thinking, person-centered service planning, and person-centered practice. PCP enables and assists the person to identify and access a personalized mix of paid and non-paid services and supports to assist him or her to achieve personally defined outcomes in the community. The CMS requires use of PCP in the development of the ISP.</p> <p>NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS: Each ISP shall contain.</p> <p>B. Long term vision: The vision statement shall be recorded in the individual's actual words, whenever possible. For example, in a long-term vision statement, the individual may describe him or herself living and working independently in the community.</p> <p>C. Outcomes: (1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not 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 7 of 30 Individuals.</p> <p>The following was found regarding the ISP:</p> <p>Individual #1:</p> <ul style="list-style-type: none"> • "...will attend cooking class once a week with ARCA Aces." Outcome does not indicate how and/or when it would be completed. • "...will choose and attend a community outing once a month." Outcome does not indicate how and/or when it would be completed. <p>Individual #6:</p> <ul style="list-style-type: none"> • "...will prepare a diabetic appropriate dish once a month." Outcome does not indicate how and/or when it would be completed. <p>Individual #8:</p> <ul style="list-style-type: none"> • Vision for Live Outcome, "...wants to increase his ability to enjoy his environment and surroundings." Outcome indicates, "...will create 4 playlists with different genres..." Review of ISP found outcome and action steps do not relate to the vision. <p>Individual #10:</p>	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>desired outcome and long-term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP.</p> <p>(2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long-term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.</p> <p>D. Individual preference: The individual's preferences, capabilities, strengths and needs in each life area determined to be relevant to the identified ISP outcomes shall be reflected in the ISP. The long-term vision, age, circumstances, and interests of the individual shall determine the life area relevance, if any to the individual's ISP.</p> <p>E. Action plans:</p> <p>(1) Specific ISP action plans that will assist the individual in achieving each identified, desired outcome shall be developed by the IDT and stated in the ISP. The IDT establishes the action plan of the ISP, as well as the criteria for measuring progress on each action step.</p> <p>(2) Service providers shall develop specific action plans and strategies (methods and procedures) for implementing each ISP desired outcome. Timelines for meeting each action step are</p>	<ul style="list-style-type: none"> • "...will participate in animal care at Mandy's Farm." Outcome does not indicate how and/or when it will be completed. <p>Individual #18:</p> <ul style="list-style-type: none"> • "...will create and implement a maintenance plan for his adopted parks." Outcomes did not indicate how and/or when they would be completed. • "...will become independent by engaging in arts and crafts activities in the community." Outcomes did not indicate how and/or when they would be completed <p>Individual #22:</p> <ul style="list-style-type: none"> • "...would like to be healthier." Outcome does not indicate how and/or when it would be completed. <p>Individual #28:</p> <ul style="list-style-type: none"> • "...will establish a close relationship with his relatives over course of his ISP year." Outcome does not indicate how and/or when it would be completed. 		
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established by the IDT. Responsible parties to oversee appropriate implementation of each action step are determined by the IDT.
(3) The action plans, strategies, timelines and criteria for measuring progress, shall be relevant to each desired outcome established by the IDT. The individual's definition of success shall be the primary criterion used in developing objective, quantifiable indicators for measuring progress.

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Tag # 4C09 Secondary FOC	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 4: Person-Centered Planning (PCP): 4.7 Choice of DD Waiver Provider Agencies and Secondary Freedom of Choice (SFOC): People receiving DD Waiver funded services have the right to choose any qualified provider of case management services listed on the PFOC and a qualified provider of any other DD Waiver service listed on SFOC form. The PFOC is maintained by each Regional Office. The SFOC is maintained by the Provider Enrollment Unit (PEU) and made available through the SFOC website: http://sfoc.health.state.nm.us/</p> <p>4.7.2 Annual Review of SFOC: Choice of Provider Agencies must be continually assured. A person has a right to change Provider Agencies if he/she is not satisfied with services at any time.</p> <ol style="list-style-type: none"> 1. The SFOC form must be utilized when the person and/or legal guardian wants to change Provider Agencies. 2. The SFOC must be signed at the time of the initial service selection and reviewed annually by the CM and the person and/or guardian. 3. A current list of approved Provider Agencies by county for all DD Waiver services is available through the SFOC website: http://sfoc.health.state.nm.us/ <p>Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record: The CM is required to maintain documentation for each person supported according to the following requirements:</p> <ol style="list-style-type: none"> 3. The case file must contain the documents identified in Appendix A Client File Matrix. <p>Chapter 20: Provider Documentation and</p>	<p>Based on record review, the Agency did not maintain the Secondary Freedom of Choice documentation (for current services) and/or ensure individuals obtained all services through the Freedom of Choice Process for 6 of 30 individuals.</p> <p>Review of the Agency individual case files revealed 11 of 134 Secondary Freedom of Choices were not found and/or not agency specific to the individual's current services:</p> <p>Secondary Freedom of Choice:</p> <ul style="list-style-type: none"> • Family Living (#9) • Customized Community Supports - Individual (#9, 18) • Customized Community Supports - Group (#4, 11, 12, 22) • Behavior Consultation (#18) • Physical Therapy (#9) • Occupational Therapy (#4) • Adult Nursing (#13) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	<p> </p>

<p>Client Records 20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p>CHAPTER 4 (CMgt) 2. Service Requirements C. Individual Service Planning: v. Secondary Freedom of Choice Process:</p> <p>A. The Case Manager will obtain a current Secondary Freedom of Choice (FOC) form that includes all service providers offering services in that region;</p> <p>B. The Case Manager will present the Secondary FOC form for each service to the individual or authorized representative for selection of direct service providers; and</p> <p>C. At least annually, rights and responsibilities are reviewed with the recipients and guardians and they are reminded they may change providers and/or the types of services they receive. At this time, Case Managers shall offer to review the current Secondary FOC list with individuals and guardians. If they are interested in changing providers or service types, a new Secondary FOC shall be completed.</p>			
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<p>Waiver services have a set of clinical criteria applied by the OR to determine clinical justification. Clinical Criteria was first implemented in October 2015 and undergoes periodic updates when clarification is needed for the field and the reviewers or when policy or program decisions affect the criteria.</p> <p>7.3.3 Adult Budget Submission Process: The CM is responsible for timely submission of the ISP, budget worksheet (BWS), and supporting documentation to the OR. To avoid any disruption or delays in approval of clinically justified services, all DD Waiver Provider Agencies on a BWS are responsible for working with the CM to assure accuracy and completeness of the submission.</p> <p>Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record: The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix.</p> <p>Chapter 20: Provider Documentation and Client Records</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p>CHAPTER 4 (CMgt) 2. Service Requirements: C. Service Planning: vi. The Case Manager ensures completion of the post IDT activities, including: A. For new allocations as well as for individuals receiving on-going services through the DDW, the Case Manager will submit the ISP to TPA Contractor only after documented verification of financial and medical eligibility has been received; B. Annually the case manager will submit the ISP</p>			
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and the Budget Worksheet and relevant prior authorizations to the TPA Contractor for review and approval prior to the ISP expiration date;
C. Prior to the delivery of any service, the TPA Contractor must approve the following:
a. The Budget Worksheet Waiver Review Form (clinical necessity) or MAD 046;
b. All Initial and Annual ISPs; and
c. Revisions to the ISP, involving changes to the budget.

Tag # 4C12 Monitoring and Evaluation of Services	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record: The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix.</p> <p>8.2.7 Monitoring and Evaluating Service Delivery: The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health and safety of the person. Monitoring and evaluation activities include the following requirements: 1. The CM is required to meet face-to-face with adult DD Waiver participants at least 12 times annually (one time per month) to bill for a monthly unit. 2. JCMs require two face-to-face contacts per month to bill the monthly unit, one of which must occur at a location in which the person spends the majority of the day (i.e., place of employment, habilitation program), and the other contact must occur at the person's residence. 3. Parents of children on the DD Waiver must receive a minimum of four visits per year, as established in the ISP. The parent is responsible for monitoring and evaluating services provided in the months case management services are not received. 4. No more than one IDT Meeting per quarter may count as a face-to-face contact for adults (including JCMs) living in the community.</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not 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 6 of 30 individuals.</p> <p>Review of the Agency individual case files revealed 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 6/2018, 10/2018, 11/2018 and 1/2019. • Individual #9 – No Face-to-Face Visit Summary Forms found for 10/2018, 3/2019 and 4/2019. <p><i>Therap Site-Visit Summary forms for 3/2019 & 4/2019 contained the date and time of visit, however, contents of the document were blank as questions were not answered.</i></p> <ul style="list-style-type: none"> • Individual #11 – No Face-to-Face Visit Summary Forms found for 7/2018 and 10/2018. • Individual #26 – No Face-to-Face Visit Summary Forms found for 9/2018 and 2/2019. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

<p>5. For non-JCMs, face-to-face visits must occur as follows:</p> <p>a. At least one face-to-face visit per quarter shall occur at the person's home for people who receive a Living Supports or CIHS.</p> <p>b. At least one face-to-face visit per quarter shall occur at the day program for people who receive CCS and or CIE in an agency operated facility.</p> <p>c. It is appropriate to conduct face-to-face visits with the person either during times when the person is receiving a service or during times when the person is not receiving a service.</p> <p>d. The CM considers preferences of the person when scheduling face-to face-visits in advance.</p> <p>e. Face-to-face visits may be unannounced depending on the purpose of the monitoring.</p> <p>6. The CM must monitor at least quarterly:</p> <p>a. that applicable MERPs and/or BCIPs are in place in the residence and at the day services location(s) for those who have chronic medical condition(s) with potential for life threatening complications, or for individuals with behavioral challenge(s) that pose a potential for harm to themselves or others; and</p> <p>b. that all applicable current HCPs (including applicable CARMP), PBSP or other applicable behavioral plans (such as PPMP or RMP), and WDSIs are in place in the applicable service sites.</p> <p>7. When risk of significant harm is identified, the CM follows the standards outlined in Chapter 18: Incident Management System.</p> <p>8. The CM must report all suspected ANE as required by New Mexico Statutes and complete all follow up activities as detailed in Chapter 18: Incident Management System.</p> <p>9. If concerns regarding the health or safety of the person are documented during monitoring or assessment activities, the CM immediately notifies appropriate supervisory personnel within the DD Waiver Provider Agency and documents the concern. In situations where the concern is not</p>	<p>Review of the Agency Individual case files revealed face-to-face visits were not being completed as required by standards (#2, #5, a, b, and c) for the following individuals:</p> <p>Individual #8 (Jackson Class Member) No second Face-to-Face found for 4/2019.No second Face-to-Face Visit Summary Forms found for 4/2019.</p> <ul style="list-style-type: none"> • 4/23/2019 – 4 - 5 pm – Site visit. <p>Individual #9 (Non-Jackson) No site visit was noted between 6/2018 - 2/2019.</p> <ul style="list-style-type: none"> • 6/18/2018 – 9:30 – 10:30 am – Home visit. • 7/16/2018 – 9:30 – 10:30 am – Home visit. • 8/20/2018 – 9:30 – 10:30 am – Home visit. • 9/17/2018 – 9:30 – 11:00 am – Home visit. • 11/2/2018 – 10:00 – 11:00 am – ISP meeting. • 12/17/2018 – 9:30 – 11:00 am – Home visit. • 1/14/2019 – 9:30 – 10:45 am – Home visit. • 2/11/2019 – 9:30 – 11:00 am – Home visit. <p>Individual #12 (Non-Jackson) No home visit was noted between 12/2018 – 4/2019.</p> <ul style="list-style-type: none"> • 12/7/2018 – 10:45 – 11:50 am – Site visit. • 1/23/2019 – 1:35 – 2:35 pm – Site visit. • 2/25/2019 – 10:20 – 11:25 am – Site visit. • 3/27/2019 – 9:55 – 11:30 am – Site visit. 		
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<p>urgent, the DD Waiver Provider Agency is allowed up to 15 business days to remediate or develop an acceptable plan of remediation.</p> <p>10. If the CMs reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed upon period of time, the CM shall use the RORA process detailed in Chapter 19: Provider Reporting Requirements.</p> <p>11. The CM conducts an online review in the Therap system to ensure that the e-CHAT and Health Passport are current: quarterly and after each hospitalization or major health event.</p> <p>14. The CM will ensure Living Supports, CIHS, CCS, and CIE are delivered in accordance with CMS Setting Requirements described in Chapter 2.1 CMS Final Rule: Home and Community-Based Services (HCBS) Settings Requirements. If additional support is needed, the CM notifies the DDSD Regional Office through the RORA process.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p>CHAPTER 4 (CMgt) 2. Service Requirements: D. Monitoring And Evaluation of Service Delivery:</p> <p>1. The Case Manager shall use a formal ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the individual specified in the ISP.</p> <p>2. Monitoring and evaluation activities shall include, but not be limited to:</p> <p>a. The case manager is required to meet face-to-face with adult DDW participants at least twelve (12) times annually (1 per month) as described in the ISP.</p> <p>b. Parents of children served by the DDW may receive a minimum of four (4) visits per year, as</p>	<ul style="list-style-type: none"> • 4/15/2019 – 12:40 – 1:50 pm – Site visit. 		
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<p>established in the ISP. When a parent chooses fewer than twelve (12) annual units of case management, the parent is responsible for the monitoring and evaluating services provided in the months case management services are not received.</p> <p>c. No more than one (1) IDT Meeting per quarter may count as a face- to-face contact for adults (including Jackson Class members) living in the community.</p> <p>d. Jackson Class members require two (2) face-to-face contacts per month, one (1) of which must occur at a location in which the individual spends the majority of the day (i.e., place of employment, habilitation program); and one must occur at the individual's residence.</p> <p>e. For non-Jackson Class members, who receive a Living Supports service, at least one face-to-face visit shall occur at the individual's home quarterly; and at least one face- to-face visit shall occur at the day program quarterly if the individual receives Customized Community Supports or Community Integrated Employment services. The third quarterly visit is at the discretion of the Case Manager.</p> <p>3. It is appropriate to conduct face-to-face visits with the individual either during times when the individual is receiving services, or times when the individual is not receiving a service. The preferences of the individual shall be taken into consideration when scheduling a visit.</p> <p>4. Visits may be scheduled in advance or be unannounced, depending on the purpose of the monitoring of services.</p> <p>5. The Case Manager must ensure at least quarterly that:</p> <p>a. Applicable Medical Emergency Response</p>			
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<p>Plans and/or BCIPs are in place in the residence and at the day services location(s) for all individuals who have chronic medical condition(s) with potential for life threatening complications, or individuals with behavioral challenge(s) that pose a potential for harm to themselves or others; and</p> <p>b. All applicable current Healthcare plans, Comprehensive Aspiration Risk Management Plan (CARMP), Positive Behavior Support Plan (PBSP or other applicable behavioral support plans (such as BCIP, PPMP, or RMP), and written Therapy Support Plans are in place in the residence and day service sites for individuals who receive Living Supports and/or Customized Community Supports (day services), and who have such plans.</p> <p>6. The Case Managers will report all suspected abuse, neglect or exploitation as required by New Mexico Statutes;</p> <p>7. 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. In situations where the concern is not urgent the provider agency will be allowed up to fifteen (15) business days to remediate or develop an acceptable plan of remediation.</p> <p>8. If the Case Manager's reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office:</p> <p>a. Submit the DDSD Regional Office Request for Intervention form (RORI); including documentation of requests and attempts (at least two) to resolve</p>			
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<p>the issue(s).</p> <p>b.The Case Management Provider Agency will keep a copy of the RORI in the individual's record.</p> <p>9. Conduct an online review in the Therap system to ensure that electronic Comprehensive Health Assessment Tools (e-CHATs) and Health Passports are current for those individuals selected for the Quarterly ISP QA Review.</p> <p>10. The Case Manager will ensure Living Supports are delivered in accordance with standards, including the minimum of thirty (30) hours per week of planned activities outside the residence. If the planned activities are not possible due to the needs of the individual, the ISP will contain an outcome that addresses an appropriate level of community integration for the individual. These activities do not need to be limited to paid supports but may include independent or leisure activities with natural supports appropriate to the needs of individual.</p> <p>11. For individuals with Intensive Medical Living Services, the IDT is not required to plan for at least thirty (30) hours per week of planned activities outside of the residence.</p> <p>12. Case Managers shall facilitate and maintain communication with the individual, guardian, his/her representative, other IDT members, providers and other relevant parties to ensure the individual receives maximum benefit from his/her services. The Case Managers ensures any needed revisions 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 DDSD Regional Office on a RORI form.</p>			
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Tag # 4C15.1 Service Monitoring - Annual / Semi-Annual Reports & Provider Semi - Annual / Quarterly Reports	Standard Level Deficiency		
<p>7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:</p> <p>C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT.</p> <p>These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed.</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record:</p> <p>The CM is required to maintain documentation for each person supported according to the following requirements:</p> <p>3. The case file must contain the documents identified in Appendix A Client File Matrix.</p> <p>8.2.7 Monitoring and Evaluating Service Delivery: The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as</p>	<p>Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 8 of 30 individuals.</p> <p>Review of the Agency individual case files revealed no evidence of quarterly/bi-annual reports for the following:</p> <p>Supported Living Semi-Annual Reports:</p> <ul style="list-style-type: none"> Individual #6 - None found for 5/2018 - 6/2018 and 11/2018 - 4/2019. (Term of ISP 11/1/2017 – 10/31/2018 and 11/1/2018 – 10/31/2019. ISP meeting held 7/12/2018). <p>Family Living Semi-Annual Reports:</p> <ul style="list-style-type: none"> Individual #10 - None found for 5/2018 - 7/2018. Report covered 8/2018 - 11/2018. (Term of ISP 5/12/2018 – 5/11/2019.) (Per regulation, reports must coincide with ISP term) <p>Behavior Support Consultation Semi-Annual Progress Reports:</p> <ul style="list-style-type: none"> Individual #6 - None found for 11/2018 - 4/2019 (Term of ISP 11/1/2018 – 10/31/2019) and report not completed 14 days prior to annual ISP meeting. (Semi-Annual Report 5/2018 - 6/2018; Date Completed: 8/1/2018; ISP meeting held on 7/12/2018) Individual #12 - None found for 12/2017 - 6/2018 and 6/2018 - 8/2018. (Term of ISP 12/9/2017-12/8/2018. ISP meeting held 9/13/2018). Individual #18- None found for 5/2018 - 11/2018 and 11/2018 - 12/2018. (Term of ISP 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	<p> </p>

<p>specified in the ISP. The CM is also responsible for monitoring the health and safety of the person...</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p>CHAPTER 4 (CMgt) 2. Service Requirements:</p> <p>C. Individual Service Planning: The Case Manager is responsible for ensuring the ISP addresses all the participant's assessed needs and personal goals, either through DDW waiver services or other means. The Case Manager ensures the ISP is updated/revised at least annually; or when warranted by changes in the participant's needs.</p> <p>1. The ISP is developed through a person-centered planning process in accordance with the rules governing ISP development [7.26.5 NMAC] and includes:</p> <p>b. Sharing current assessments, including the SIS assessment, semi-annual and quarterly reports from all providers, including therapists and BSCs. Current assessment shall be distributed by the authors to all IDT members at least fourteen (14) calendar days prior to the annual IDT Meeting, in accordance with the DDS Consumer File Matrix Requirements. The Case Manager shall notify all IDT members of the annual IDT meeting at least twenty-one (21) calendar days in advance:</p> <p>D. Monitoring And Evaluation of Service Delivery:</p> <p>1. The Case Manager shall use a formal ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the individual specified in the ISP.</p> <p>5. The Case Manager must ensure at least quarterly that:</p>	<p>5/5/2018 - 5/4/2019. <i>ISP meeting held 1/14/2019).</i></p> <ul style="list-style-type: none"> • Individual #29 - None found for 3/2018 - 8/2018. <i>(Term of ISP 3/1/2018 - 2/28/2019.</i> <p>Nursing Semi-Annual Reports:</p> <ul style="list-style-type: none"> • Individual #4 – No documented evidence that Case Manager followed up when report was not provided 14 days prior to the Annual ISP meeting. <i>(Semi-Annual Report 12/20/2018 – 3/20/2019; Date Completed:6/23/2019; ISP meeting held on 3/19/2019)</i> • Individual #6 - None found for 5/2018 - 6/2018. <i>(Term of ISP 11/1/2018 - 10/31/2019. ISP meeting held 7/12/2018).</i> • Individual #9 - None found for 7/2018 - 1/2019. <i>(Term of ISP 7/26/2018 - 7/25/2019.)</i> • Individual #11 – <i>Term of ISP 11/1/2018 - 10/31/2019. ISP meeting held on 7/27/2018, the following was found:</i> Ability First (Family Living) - None found for 11/2018 - 4/2019 and no documented evidence that Case Manager followed up when report was not provided 14 days prior to the Annual ISP meeting. <i>Date completed 8/9/2018.</i> <p>VSA (CCS-G) - No documented evidence that Case Manager followed up report was not provided 14 days prior to the Annual ISP meeting. <i>Date Completed 11/29/2018.</i></p> <ul style="list-style-type: none"> • Individual #12 - None found for 6/2018 - 8/2018. <i>(Term of ISP 12/9/2018 - 12/8/2019. ISP meeting held 9/13/2018).</i> 		
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<p>a. Applicable Medical Emergency Response Plans and/or BCIPs are in place in the residence and at the day services location(s) for all individuals who have chronic medical condition(s) with potential for life threatening complications, or individuals with behavioral challenge(s) that pose a potential for harm to themselves or others; and</p> <p>b. All applicable current Healthcare plans, Comprehensive Aspiration Risk Management Plan (CARMP), Positive Behavior Support Plan (PBSP or other applicable behavioral support plans (such as BCIP, PPMP, or RMP), and written Therapy Support Plans are in place in the residence and day service sites for individuals who receive Living Supports and/or Customized Community Supports (day services), and who have such plans.</p> <p>6. The Case Managers will report all suspected abuse, neglect or exploitation as required by New Mexico Statutes;</p> <p>7. 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. In situations where the concern is not urgent the provider agency will be allowed up to fifteen (15) business days to remediate or develop an acceptable plan of remediation.</p> <p>8. If the Case Manager's reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office:</p> <p>a. Submit the DDSD Regional Office Request for</p>	<ul style="list-style-type: none"> • Individual #17 - None found for 5/2018–6/2018. (Term of ISP 11/1/2018 - 10/31/2019. ISP meeting held 7/12/2018). 		
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Intervention form (RORI); including documentation of requests and attempts (at least two) to resolve the issue(s).

b. The Case Management Provider Agency will keep a copy of the RORI in the individual's record.

9. Conduct an online review in the Therap system to ensure that electronic Comprehensive Health Assessment Tools (e-CHATs) and Health Passports are current for those individuals selected for the Quarterly ISP QA Review.

10. The Case Manager will ensure Living Supports are delivered in accordance with standards, including the minimum of thirty (30) hours per week of planned activities outside the residence. If the planned activities are not possible due to the needs of the individual, the ISP will contain an outcome that addresses an appropriate level of community integration for the individual. These activities do not need to be limited to paid supports but may include independent or leisure activities with natural supports appropriate to the needs of individual.

11. For individuals with Intensive Medical Living Services, the IDT is not required to plan for at least thirty (30) hours per week of planned activities outside of the residence.

Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)	Condition of Participation Level Deficiency		
<p>NMAC 7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:</p> <p>A.The case manager shall provide copies of the completed ISP, with all relevant service provider strategies attached, within fourteen (14) days of ISP approval to:</p> <ul style="list-style-type: none"> (1) the individual; (2) the guardian (if applicable); (3) all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons; (4) all other IDT members in attendance at the meeting to develop the ISP; (5) the individual's attorney, if applicable; (6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies; (7) for all developmental disabilities Medicaid waiver recipients, including <i>Jackson</i> class members, a copy of the completed ISP containing all the information specified in 7.26.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD; (8) for <i>Jackson</i> class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the <i>Jackson</i> lawsuit office of the DDSD. <p>B.Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review and/or interview the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 11 of 30 Individual:</p> <p>No Evidence found indicating ISP was distributed:</p> <ul style="list-style-type: none"> • Individual #8: No evidence ISP was provided to: Guardian/Individual, and Providers. • Individual #9: No evidence ISP was provided to: Guardian/Individual. • Individual #12: No evidence ISP was provided to Guardian/Individual and Providers. • Individual #16: No evidence that ISP was distributed to Guardian/Individual and Providers. • Individual #17: No evidence ISP was provided to Guardian/Individual and Providers. • Individual #20: No evidence ISP was provided to Guardian/Individual and Providers. • Individual #29: No evidence ISP was provided to Guardian/Individual. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (<i>What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019

Chapter 6 Individual Service Plan (ISP) 6.7 Completion and Distribution of the ISP: The CM is required to assure all elements of the ISP and companion documents are completed and distributed to the IDT. However, DD Waiver Provider Agencies share responsibility to contribute to the completion of the ISP. The ISP must be completed and approved prior to the expiration date of the previous ISP term. Within 14 days of the approved ISP and when available, the CM distributes the ISP to the DDSD Regional Office, the DD Waiver Provider Agencies with a SFOC, and to all IDT members requested by the person.

Evidence indicated ISP was provided after 14 day window:

- Individual #1: *ISP approval date was 6/21/2018, ISP was sent to Guardian/Individual and the LCA/CI Provider Agencies on 7/13/2018.*
- Individual #4: *ISP approval date was 5/17/2018, ISP was sent to Guardian, OT, PT, SLP, LCA/CI Provider Agencies on 9/14/2018.*
- Individual #9: *ISP approval date was 7/25/2018, ISP was sent to LCA/CI Provider Agencies on 9/19/2018.*
- Individual #11: *ISP approval date was 10/26/2018, ISP was sent to Guardian and LCA/CI Provider Agencies on 12/13/2018.*

Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)	Standard Level Deficiency		
<p>NMAC 7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:</p> <p>A. The case manager shall provide copies of the completed ISP, with all relevant service provider strategies attached, within fourteen (14) days of ISP approval to:</p> <ol style="list-style-type: none"> (1) the individual; (2) the guardian (if applicable); (3) all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons; (4) all other IDT members in attendance at the meeting to develop the ISP; (5) the individual's attorney, if applicable; (6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies; (7) for all developmental disabilities Medicaid waiver recipients, including <i>Jackson</i> class members, a copy of the completed ISP containing all the information specified in 7.26.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD; (8) for <i>Jackson</i> class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the <i>Jackson</i> lawsuit office of the DDSD. <p>B. Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p>	<p>Based on record review and/or interview the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 8 of 30 Individual:</p> <p>Evidence indicated ISP was provided after 14-day window:</p> <ul style="list-style-type: none"> • Individual #1: <i>ISP approval date was 6/21/2018, ISP was sent to the DDSD Regional Office on 7/13/2018.</i> • Individual #4: <i>ISP approval date was 5/17/2018, ISP was sent to the DDSD Regional Office on 10/24/2018.</i> • Individual #9: <i>ISP approval date was 7/25/2018, ISP was sent to the DDSD Regional Office on 11/2/2018.</i> • Individual #20: <i>ISP approval date was 5/10/2019, ISP was sent to the DDSD Regional Office on 6/23/2019.</i> • Individual #21: <i>ISP approval date was 4/11/2019, ISP was sent to the DDSD Regional Office on 5/29/2019.</i> <p>No Evidence found indicating ISP was distributed:</p> <ul style="list-style-type: none"> • Individual #12: <i>No evidence ISP was provided to DDSD.</i> • Individual #16: <i>No evidence that ISP was provided to DDSD.</i> • Individual #17: <i>No evidence ISP was provided to DDSD.</i> 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (<i>What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

Chapter 6 Individual Service Plan (ISP) 6.7 Completion and Distribution of the ISP: The CM is required to assure all elements of the ISP and companion documents are completed and distributed to the IDT. However, DD Waiver Provider Agencies share responsibility to contribute to the completion of the ISP. The ISP must be completed and approved prior to the expiration date of the previous ISP term. Within 14 days of the approved ISP and when available, the CM distributes the ISP to the DDSD Regional Office, the DD Waiver Provider Agencies with a SFOC, and to all IDT members requested by the person.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Qualified Providers - The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.			
Tag # 1A22/4C02 Case Manager - Individual Specific Competencies	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 8 Case Management: 8.2 Scope: DD Waiver CMs must have knowledge of the requirements for the entire system to effectively provide and monitor services. In general, the CM's scope of practice is to:</p> <ol style="list-style-type: none"> 1. promote self-advocacy and advocate on behalf of the person; 2. facilitate and monitor the allocation and annual recertification processes as well as transitions as described in Chapter 9: Transitions; 3. participate in specific assessment activities related to annual LOC determination and PCP; 4. link the person and guardian to publicly funded programs, community resources and non-disability specific resources available to all citizens and natural supports within the person's community; 5. organize and facilitate the PCP process and ISP development in accordance with the DD Waiver Service Standards as described in Chapter 4: Person-Centered Planning and Chapter 6: Individual Service Plan (ISP); 6. submit the ISP and the Waiver Budget Worksheet (BWS) or MAD 046 and any other required documents to TPA Contractor(s), as outlined in Chapter 7: Available Services and Individual Budget Development; 7. monitor the ISP implementation including service delivery, coordination of other supports, and health and safety assurances as described in the ISP; and 8. maintain a complete record for each person in 	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on interview, the Agency did not ensure each case manager met the IST requirements in accordance with the specifications described in the ISP of each person supported for 2 of 9 Case Managers.</p> <p>When the Case Manager was asked if the Individual had Healthcare Plans and/or Medical Emergency Response Plans, the following was reported:</p> <ul style="list-style-type: none"> • #501 stated, "I don't have any MERPs for him." When Surveyor showed Case Manager the eCHAT summary page, Case Manager #501 stated, "Oh, he does, I'll need to get those for you." According to the Electronic Comprehensive Health Assessment Tool, the individual requires plans for Anaphylactic reaction, neuro device, seizure, respiratory, seizures, and falls (Individual #2) • #504 stated, "... has a HCP for hearing and podiatry. I don't think she has any MERPs." Case Manager checked the Individual's file and stated, "nope, no MERPs." According to the Electronic Comprehensive Health Assessment Tool, the individual requires a Medical Emergency Response Plan for Endocrine A1c Levels. (Individual #12) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

services, as specified in Chapter 20: Provider Documentation and Client Records and Appendix A Client File Matrix.

8.2.1 Promoting Self Advocacy and Advocating on Behalf of the Person in Services:

A primary role of the CM is to facilitate self-advocacy and advocate on behalf of the person, which includes, but is not limited to:
1. Operating under the Employment First Principle and facilitating employment decisions based on informed choice....

2. Monitoring to determine if reasonable accommodations are made including assistive technology.

3. Using PCP which aids people to advocate for themselves, as needed and when appropriate.

4. Notifying the DDS Regional Office, through the RORA process, if supports are unavailable.

5. Documenting through ISP meeting minutes, contact notes, or DDS issued forms and templates that decisions made by the person and/or the guardian are based on the completion of required elements of informed choice as outlined in Chapter 4.5 Informed Choice.

6. Educating other healthcare and DD Waiver Provider Agencies in recognizing and respecting the needs, strengths, and goals of the person.

7. Facilitating IDT meetings in a manner that promotes conflict free service and support coordination as described in Chapter 4.8 Conflict-Free Service and Support Coordination.

8. Ensuring that a discussion on individualized Meaningful Day activities occurs in the ISP meeting and is reflected in the ISP.

9. Ensuring that a discussions of non-disability specific options and actions to increase self-determination occurs in the planning process, before development of the annual budget, and is documented in IDT meeting minutes, contact notes, or relevant DDS Issued forms and templates.

<p>10. Reviewing the HCBS Consumer Rights and Freedoms with the person and guardian as applicable, at least annually and in a form/format most understandable by the person. (See Appendix C HCBS Consumer Rights and Freedoms.)</p> <p>11. Confirming acknowledgement of the HCBS Consumer Rights and Freedoms with signatures of the person and guardian, if applicable.</p> <p>12. Reviewing the ISP Addendum A at least annually to discuss: Individual Client Rights, Client Complaint Procedure, the Dispute Resolution Process, and ANE reporting, with the person and guardian as applicable and in a form/format most understandable by the person.</p> <p>13. Confirming acknowledgement of the receipt Addendum A with signatures of the person and guardian, if applicable.</p> <p>14. Discussing and providing information regarding hospice services, palliative care, and end of life care, when appropriate.</p> <p>15. Leading the SFOC process as described in Chapter 4.7.2 Annual Review of SFOC including specific responsibilities to...</p> <p>8.3.1 CM Qualifications and Training Requirements:</p> <p>Within specified timelines, Case Management Provider Agencies must assure that all CMs meet the requirements for pre-service and core competency training as specified in the Chapter 17: Training Requirements.</p>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Health, Safety and Welfare - The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.			
Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 22: Quality Improvement Strategy (QIS): A QIS at the provider level is directly linked to the organization's service delivery approach or underlying provision of services. To achieve a higher level of performance and improve quality, an organization is required to have an efficient and effective QIS. The QIS is required to follow four key principles:</p> <ol style="list-style-type: none"> 1. quality improvement work in systems and processes; 2. focus on participants; 3. focus on being part of the team; and 4. focus on use of the data. <p>As part of a QIS, Provider Agencies are required to evaluate their performance based on the four key principles outlined above. Provider Agencies are required to identify areas of improvement, issues that impact quality of services, and areas of non-compliance with the DD Waiver Service Standards or any other program requirements. The findings should help inform the agency's QI plan.</p> <p>22.2 QI Plan and Key Performance Indicators (KPI): Findings from a discovery process should result in a QI plan. The QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving goals, and identifying opportunities for improvement. The QI plan describes the processes that the Provider Agency uses in each phase of the QIS: discovery, remediation, and sustained improvement. It</p>	<p>Based on record review and interview, the Agency did not maintain a Quality Improvement System (QIS), as required by standards.</p> <p>The Agency's QI Plan did not address the following KPI:</p> <ul style="list-style-type: none"> • % of Individuals whose Individual Support Plans (ISP) are implemented as written • % of appointments attended as recommended by medical professionals (physician, nurse practitioner or specialist). • % of people accessing Customized Community Supports in a non-disability specific setting. <p>When asked if the Agency had a Quality Improvement Plan (QPI) that includes the Key Performance Indicators as outlined by DDSD, the following was reported:</p> <ul style="list-style-type: none"> • #509 stated, "...Didn't have with the last write-up of the QA/QI plan. QA/QI plan written June 2018. Started tracking KPIs January 1, 2019." 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (<i>What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?</i>): →</p>	

<p>describes the frequency of data collection, the source and types of data gathered, as well as the methods used to analyze data and measure performance. The QI plan must describe how the data collected will be used to improve the delivery of services and must describe the methods used to evaluate whether implementation of improvements is working. The QI plan shall address, at minimum, three key performance indicators (KPI). The KPI are determined by DOH-DDS(QI) on an annual basis or as determined necessary.</p> <p>22.3 Implementing a QI Committee: A QI committee must convene on at least a quarterly basis and more frequently if needed. The QI Committee convenes to review data; to identify any deficiencies, trends, patterns, or concerns; to remedy deficiencies; and to identify opportunities for QI. QI Committee meetings must be documented and include a review of at least the following:</p> <ol style="list-style-type: none"> 1. Activities or processes related to discovery, i.e., monitoring and recording the findings; 2. The entities or individuals responsible for conducting the discovery/monitoring process; 3. The types of information used to measure performance; 4. The frequency with which performance is measured; and 5. The activities implemented to improve performance. <p>NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:</p> <p>F. Quality assurance/quality improvement program for community-based service providers: The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's</p>			
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<p>investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program:</p> <ul style="list-style-type: none">(1) community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements;(2) community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and(3) community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.			
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Tag # 1A15.2 Administrative Case File - Healthcare Documentation (Therap and Required Plans)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record: The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix.</p> <p>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all</p>	<p>Based on record review, the Agency did not maintain a complete client record at the administrative office for 5 of 30 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p>Health Care Plans:</p> <ul style="list-style-type: none"> • <i>Diabetes</i> <ul style="list-style-type: none"> • Individual #12 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found. <p>Medical Emergency Response Plans:</p> <ul style="list-style-type: none"> • <i>Aspiration</i> <ul style="list-style-type: none"> • Individual #10 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found. • Individual #17 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found. • Individual #29 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found. (Note: Plan created after survey start date on 6/22/2019.) • <i>Diabetes</i> <ul style="list-style-type: none"> • Individual #12 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found. • <i>Respiratory</i> 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	<p> </p>

<p>documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</p> <p>5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p> <p>Chapter 3 Safeguards: 3.1.1 Decision Consultation Process (DCP): Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following:</p> <p>1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to:</p> <p>a. medical orders or recommendations from the</p>	<ul style="list-style-type: none"> Individual #29 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found. <p>Nutritional Plan:</p> <ul style="list-style-type: none"> Individual #4 - As indicated by the IST section of the ISP, the individual is required to have a plan. No evidence of plan found. 		
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<p>Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;</p> <p>b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy;</p> <p>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and</p> <p>d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.</p> <p>2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting:</p> <p>a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation.</p> <p>b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation.</p> <p>c. Providers support the person/guardian to make an informed decision.</p> <p>d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.</p>			
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Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015

CHAPTER 4 (CMgt) I. Case Management

Services: 1. Scope of Services: S. Maintain a complete record for the individual's DDW services, as specified in DDSD Consumer Records Requirements Policy;

understandable by the person.

8.2.8 Maintaining a Complete Client Record:

The CM is required to maintain documentation for each person supported according to the following requirements:

3. The case file must contain the documents identified in Appendix A Client File Matrix.

4. All pages of the documents must include the person's name and the date the document was prepared.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Medicaid Billing/Reimbursement - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.			
Tag # 4C21 Case Management Reimbursement	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p>Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:</p> <p>DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following:</p> <ol style="list-style-type: none"> 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: <ol style="list-style-type: none"> a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and h. the nature of services. 3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding 	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed, which contained the required information for 1 of 30 individuals.</p> <p>Individual #8 April 2019</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Case Management from 4/1/2019 through 4/30/2019. Documentation accounted for .5 units. Per standards Jackson Class Members require two face-to-face contacts per month to bill the monthly unit. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>settlement of any claim, whichever is longer.</p> <p>21.9.2 Requirements for Monthly Units: For services billed in monthly units, a Provider Agency must adhere to the following:</p> <ol style="list-style-type: none"> 1. A month is considered a period of 30 calendar days. 2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. 4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit. <p>Chapter 8 Case Management - 8.2.7 Monitoring and Evaluating Service Delivery: The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health and safety of the person. Monitoring and evaluation activities include the following requirements:</p> <ol style="list-style-type: none"> 1. The CM is required to meet face-to-face with adult DD Waiver participants at least 12 times annually (one time per month) to bill for a monthly unit. 2. JCMs require two face-to-face contacts per month to bill the monthly unit, one of which must occur at a location in which the person spends the majority of the day (i.e., place of employment, habilitation program), and the other contact must occur at the person's residence. 			
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Date: October 16, 2019

To: Anthony L. Ross, Executive Director
Provider: Amigo Case Management, Inc.
Address: 2610 San Mateo Blvd., NE, Suite B
City, State, Zip: Albuquerque, New Mexico 87110

E-mail Address: acm2130@aol.com

Board Secretary: Cristy J. Carbon-Gaul
E-Mail Address: cristy@carbon-gaul.com

Region: Metro
Survey Date: June 21 - 27, 2019
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2018: Case Management**

Survey Type: Routine

Dear Mr. Anthony L. Ross;

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

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