Date: November 20, 2015

To: Elizabeth Sandoval, Social Work Supervisor
Provider: New Mexico Behavioral Health Institute
Address: 700 Friedman Avenue
State/Zip: Las Vegas, New Mexico 87701

E-mail Address: Elizabeth.Sandoval2@state.nm.us

CC: Corrine Dominguez, Director Community Based Services
E-mail Address: Corrine.Dominguez@state.nm.us

CC: Dr. Troy Jones, Executive Director/Administrator
E-mail Address: Troy.Jones@state.nm.us

Region: Northeast
Survey Date: October 30 – November 4, 2015
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: ***2007 & 2012:*** Case Management
Survey Type: Routine

Team Leader: Florence G. Mulheron, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Leslie Peterson, MA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Corrina B. Strain, RN, BSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Sandoval;

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:

Compliance with all Conditions of Participation.

This determination is based on your agency's compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

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

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

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

1. **Quality Management Bureau, Attention: 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 claims 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: Julie Ann Hill-Clapp
HSD/OIG
Program Integrity Unit
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Or if using UPS, FedEx, DHL (courier mail) send to physical address at:

Attention: Julie Ann Hill-Clapp
HSD/OIG
Program Integrity Unit
2025 S. Pacheco Street
Santa Fe, New Mexico 87505

Please be advised that there is a one-week lag period for applying payments received by check to Voided/Adjusted 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:

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

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

Please call the Plan of Correction Coordinator 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,

Florence G. Mulheron, BA

Florence G. Mulheron, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	November 2, 2015	
Present:	**New Mexico Behavioral Health Institute** Elizabeth Sandoval, Case Manager Supervisor Kimberly Sena, Case Manager Marcine Vigil, Case Manager **DOH/DHI/QMB** Florence G. Mulheron, BA, Team Lead/Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor Leslie Peterson, MA, Health Care Surveyor Corrina B. Strain, RN, BSN, Health Care Surveyor	
Exit Conference Date:	November 4, 2015	
Present:	**New Mexico Behavioral Health Institute** Corrine Dominguez, Director Community Based Services Elizabeth Sandoval, Case Manager Supervisor Kimberly Sena, Case Manager Marcine Vigil, Case Manager **DOH/DHI/QMB** Florence G. Mulheron, BA, Team Lead/Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor Leslie Peterson, MA, Health Care Surveyor Corrina B. Strain, RN, BSN, Health Care Surveyor **DDSD – Northeast Regional Office** Angela Pacheco, Regional Director (via Telephone Conference)	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	15 1 - *Jackson* Class Members 14 - Non-*Jackson* Class Members
Persons Served Records Reviewed	Number:	15
Total Number of *Secondary Freedom of Choices* Reviewed:	Number:	53
Case Managers Interviewed	Number:	3
Case Mgt Personnel Records Reviewed	Number:	3

Administrative Files Reviewed

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Individual Medical and Program Case Files, including, but not limited to:
    - Individual Service Plans
    - Progress on Identified Outcomes
    - Healthcare Plans
    - 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
- Personnel Files
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
MFEAD – NM Attorney General

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 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 to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

The Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

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

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc.;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data 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 the documents do not contain protected Health information (PHI) the preferred method is that you 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. In addition to this, we ask that you submit:
    a. Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
    b. Copies of "void and adjust" forms submitted to Xerox State Healthcare, LLC to correct all unjustified units identified and submitted for payment during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, 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 state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan 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 Management 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 in the QMB Report of Findings. 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.

Within the QMB Service Domains there are fundamental regulations, standards, or policies with which a provider must be in essential compliance in order to ensure the health and welfare of individuals served known as Conditions of Participation (CoPs).

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in three (3) Service Domains.

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

- Qualified Provider
- Plan of Care
- Health, Welfare and Safety

Conditions of Participation (CoPs)

A CoP is an identified fundamental regulation, standard, or policy with which a provider must be in compliance in order to ensure the health and welfare of individuals served. CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances. A provider must be in compliance with CoPs to participate as a waiver provider.

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP (See the next section for a list of CoPs). The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

CoPs and Service Domains for Case Management Supports are as follows:

Service Domain: Level of Care

Condition of Participation:

1. **Level of Care**: The Case Manager shall complete all required elements of the Long Term Care Assessment Abstract (LTCAA) to ensure ongoing eligibility for waiver services.

Service Domain: Plan of Care

Condition of Participation:

2. **Individual Service Plan (ISP) Creation and Development**: Each individual shall have an ISP. The ISP shall be developed in accordance with DDSD regulations and standards and is updated at least annually or when warranted by changes in the individual's needs.

Condition of Participation:

3. **ISP Monitoring and Evaluation:** The Case Manager shall ensure the health and welfare of the individual through monitoring the implementation of ISP desired outcomes.

CoPs and Service Domain for ALL Service Providers is as follows:

Service Domain: Qualified Providers

Condition of Participation:

4. **Qualified Providers**: Agencies shall ensure support staff has completed criminal background screening and all mandated trainings as required by the DDSD.

CoPs and Service Domains for Living Supports and Inclusion Supports are as follows:

Service Domain: Plan of Care

Condition of Participation:

5. **ISP Implementation**: Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

Service Domain: Health, Welfare and Safety

Condition of Participation:

6. **Individual Health, Safety and Welfare: (Safety)** Individuals have the right to live and work in a safe environment.

Condition of Participation:

7. **Individual Health, Safety and Welfare (Healthcare Oversight)**: The provider shall support individuals to access needed healthcare services in a timely manner. Nursing, healthcare services and healthcare oversight shall be available and provided as needed to address individuals' health, safety and welfare.

QMB Determinations of Compliance

Compliance with Conditions of Participation

The QMB determination of *Compliance with Conditions of Participation* indicates that a provider is in compliance with all Conditions of Participation, (CoP). The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation in all relevant Service Domains. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) out of compliance in any of the Service Domains.

Partial-Compliance with Conditions of Participation

The QMB determination of *Partial-Compliance with Conditions of Participation* indicates that a provider is out of compliance with Conditions of Participation in one (1) to two (2) Service Domains. The agency may have one or more Condition level tags within a Service Domain. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains.

Providers receiving a repeat determination of Partial-Compliance for repeat deficiencies at the level of a Condition in any Service Domain may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

Non-Compliance with Conditions of Participation

The QMB determination of *Non-Compliance with Conditions of Participation* indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains. 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. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

Providers receiving a repeat determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

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: http://dhi.health.state.nm.us/qmb
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the 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.

Agency: **New Mexico Behavioral Health Institute - Northeast Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** Case Management & ***2007:*** Case Management
Monitoring Type: Routine Survey
Survey Date: **October 30 – November 4, 2015**

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Plan of Care - ISP Development & Monitoring – *Service plans address all participates' assessed needs (including health and safety risk factors) and goals, either by waiver services or through other means. Services plans are updated or revised at least annually or when warranted by changes in the waiver participants' needs.*			
Tag # 1A08 Agency Case File	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **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; **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications:** A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 10 of 15 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • **ISP Teaching & Support Strategies** ◦ Individual #9 - TSS not found for: ◦ *(Live) Outcome Statement:* ➢ "… will follow instruction to prepare a dish of his choice." • **Dental Exam** ◦ Individual #3 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found. • **Auditory Exam** ◦ Individual #1 - As indicated by the progress notes and the assessment checklist reviewed, exam was completed on 6/3/2013. Follow-up was to be completed in	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of	1 year. No documented evidence of the follow-up being completed was found. ◦ Individual #3 - As indicated by the progress notes reviewed, exam was completed on 6/9/2011. Follow-up was to be completed in 24 months. No documented evidence of the follow-up being completed was found. ◦ Individual #9 - As indicated by the progress notes reviewed, exam was completed on 9/5/2013. Follow-up was to be completed in 2 years. No documented evidence of the follow-up being completed was found. ◦ Individual #10 - As indicated by the progress notes reviewed, exam was completed on 8/29/2013. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. • **Vision Exam** ◦ Individual #1 - As indicated by the progress notes and the assessment checklist reviewed, exam was completed on 9/27/2012. Follow-up was to be completed in 1 - 2 years. No documented evidence of the follow-up being completed was found. ◦ Individual #6 - As indicated by the medical eye appointment form reviewed, exam was completed on 10/28/2014. Follow-up was to be completed in 12 months. No documented evidence of the follow-up being completed was found. ◦ Individual #12 - As indicated by the progress notes, exam was completed on 4/21/2014. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found.		

the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.	◦ Individual #13 - As indicated by the assessment checklist, exam was completed on 8/26/2014. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. • Speech Therapy Plan (#2, 13) • Occupational Therapy Plan (#15) • **Medical Emergency Response Plans** • *Aspiration* ◦ Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • Speech/Language Therapy Evaluation (#2) • **Bone Density Exam** ◦ Individual #15 - As indicated by the annual health physical reviewed, exam was recommended on 3/9/2015. No documented evidence was found to verify visit was completed. • **Cholesterol** ◦ Individual #4 - As indicated by the annual health and physical exam progress notes reviewed, lab work is to be completed annually 3/18/2015. No documented evidence was found to verify it was completed.		

Tag # 4C01.2 Case Management Services – Supports Intensity Scale	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 4 (CMgt) I. Case Management Services:** Case Management Services assist participants in gaining access to needed Developmental Disabilities Waiver (DDW) and State Plan services. Case Managers link the individual to needed medical, social, educational and other services, regardless of funding source. Waiver services are intended to enhance, not replace existing natural supports and other available community resources. Case Management Services will emphasize and promote the use of natural and generic supports to address the individuals assessed needs in addition to paid supports. Case Managers facilitate and assist in assessment activities. Case Management services are person-centered and intended to support individuals in pursuing their desired life outcomes while gaining independence and access to needed services and supports. Case Management is a set of interrelated activities that are implemented in a collaborative manner involving the active participation of the individual, their designated representative/guardian, and the entire Interdisciplinary Team (IDT). The Case Manager serves as an advocate for the individual, and is responsible for the development of the Individual Service Plan (ISP) and the ongoing monitoring of the provision of services included in the ISP. **New Mexico Developmental Disabilities Waiver Supports Intensity Scale® (SIS) Reassessment Approval Policy effective May 24, 2013** **II. POLICY STATEMENT** It is the policy of the DOH Developmental Disabilities Supports Division (DDSD) to establish criteria for the Department of Health (DOH) employees or agents to follow when reviewing requests for a SIS reassessment	Based on record review the Agency did not assure that the Supports Intensity Scale (SIS) was completed as required by the Department of Health (DOH) / Developmental Disabilities Support Division policies for 1 of 15 individuals. Review of documentation found the following were not current, missing or incomplete: • Supports Intensity Scale: Individual #2 last completed on 3/13/2012. Not completed every 3 years as required.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

prior to the standard three-year cycle established in DDSD policy DDSD DDW 12.1. These policies address the use of the SIS as the basis for determining the support needs and subsequent assignment of a New Mexico Developmental Disabilities Waiver (DDW) Group. **Department of Health Developmental Disabilities Supports Division (DDSD)** **Procedure Number: DDSD DDW-12.5.a** **Procedure Title: New Mexico Developmental Disabilities Waiver Supports Intensity Scale® (SIS) Reassessment Approval Procedure** **Effective Date: December 3, 2013** **II. PURPOSE OF PROCEDURE** This procedure establishes a process for approving SIS reassessment requests prior to the standard three-year cycle established in policy Developmental Disabilities Supports Division DDSD DDW12.1 regarding use of the SIS as the basis for determining the support needs and, assigning a NM Developmental Disabilities Waiver (DDW) Group **IV. DEFINITIONS** ***Supports Intensity Scale® (SIS) Assessment:*** A reliable, valid, standardized assessment designed to measure the pattern and intensity of supports a person (18 years and older) with intellectual disabilities requires to be successful in community settings. The SIS was developed by AAIDD between 1998 and 2003 and was released for use in 2004. ***SIS Reassessment:*** The complete SIS assessment conducted prior to the standard three year cycle established by DDSD policy regarding use of the SIS assessment.			

Tag # 4C02 Scope of Services - Primary Freedom of Choice	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013**CHAPTER 4 (CMgt) I. Case Management Services: 1. Scope of Services: T.** Ensure individuals obtain all services through the Freedom of Choice (FOC) process. **2. Service Requirements B. Assessment:** 2. Review and Approval of the Long Term Care Assessment Abstract by the TPA Contractor: a. The Case Manager will submit the Long Term Care Assessment Abstract packet to the TPA Contractor for review and approval. If it is an initial allocation, submission shall occur within ninety (90) calendar days from the date the DDSD receives the individual's Primary Freedom of Choice (FOC) selecting the DDW as well as their Case Management Freedom of Choice selection. All initial Long Term Care Assessment Abstracts must be approved by the TPA Contractor prior to service delivery; Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 II. SCOPE OF CASE MANAGEMENT SERVICES:** Case Management shall include, but is not limited to, the following services: **T.** Assure individuals obtain all services through the Freedom of Choice process.	Based on record review the Agency did not maintain documentation assuring individuals obtained all services through the freedom of choice process for 1 of 15 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Primary Freedom of Choice (#4)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Tag # 4C10 Apprv. Budget Worksheet Waiver Review Form / MAD 046	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **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 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. 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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS** **H. Case Management Approval of the MAD 046 Waiver Review Form and Budget** (1) Case Management Providers are authorized by DDSD to approve ISPs and budgets (including initial, annual renewals and revisions) for all individuals except as	Based on record review the Agency did not maintain documentation ensuring the Case Manager completed the Budget Worksheet Waiver Review Form or MAD046 Waiver Review Form for 4 of 15 individuals. The following item was not found: • Budget Worksheet Waiver Review Form or MAD 046 (#8, 10 & 15) *(Note: No Plan of Correction required as delay was due to TPA)* • Prior Authorization for Speech Therapy (#2)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

noted in section I of this chapter. This includes approval of support plans and strategies as incorporated in the ISP. (2) The Case Manager shall complete the MAD 046 Waiver Review Form and deliver it to all provider agencies within three (3) working days following the ISP meeting date. Providers will have the opportunity to submit corrections or objections within five (5) working days following receipt of the MAD 046. If no corrections or objections are received from the provider by the end of the fifth (5) working day, the MAD 046 may then be submitted as is to NMMUR. (Provider signatures are no longer required on the MAD 046.) If corrections/objections are received, these will be corrected or resolved with the provider(s) within the timeframe that allow compliance with number (3) below. (3) The Case Manager will submit the MAD 046 Waiver Review Form to NMMUR for review as appropriate, and/or for data entry at least thirty (30) calendar days prior to expiration of the previous ISP. (4) The Case Manager shall respond to NMMUR within specified timelines whenever a MAD 046 is returned for corrections or additional information.			

Tag # 4C12 Monitoring & Evaluation of Services	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 4 (CMgt) 2. Service Requirements: D. Monitoring And Evaluation of Service Delivery:** 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. 2. Monitoring and evaluation activities shall include, but not be limited to: 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. b. Parents of children served by the DDW may receive a minimum of four (4) visits per year, as 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. 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. 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. e. For non-Jackson Class members, who receive a Living Supports service, at least one face-to-face visit shall occur at the	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 4 of 15 individuals. **Review of the Agency individual case files revealed face-to-face visits were no being completed as required by standard (2 b, c & d) for the following individuals:** Individual #1 (Non-Jackson) • One Home visit was noted between 10/2014 - 9/2015. *Per requirements 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.* Individual #2 (Non-Jackson) • No day site visit was noted between 10/2014 - 9/2015. *Per requirements 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.* Individual #7 (Non-Jackson) • No day site visit was noted between 12/2014 - 5/2015. *Per requirements 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.* **Review of the Agency individual case files revealed face-to-face visits were not completed as required by standard (2 b, c & d) for the following individuals:** Individual #15 (Jackson Class Member)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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. 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. 4. Visits may be scheduled in advance or be unannounced, depending on the purpose of the monitoring of services. 5. The Case Manager must ensure at least quarterly that: 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 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.	• No documentation of site visit was found for 8/2015. ◦ 8/6/2015 – 3:00 PM – Home Visit		

6. The Case Managers will report all suspected abuse, neglect or exploitation as required by New Mexico Statutes; 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. 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: a. Submit the DDSD Regional Office Request for 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. 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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS: J. Case Manager Monitoring and Evaluation of Service Delivery** (1) The Case Manager shall use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual as specified in the ISP. (2) Monitoring and evaluation activities shall include, but not be limited to: (a) Face-To-Face Contact: A minimum of twelve (12) face-to-face contact visits annually (1 per month) is required to occur between the Case Manager and the individual served as			

described in the ISP; an exception is that children may receive a minimum of four visits per year; (b) Jackson Class members require two (2) face-to–face contacts per month, one of which occurs at a location in which the individual spends the majority of the day (i.e., place of employment, habilitation program) and one at the person's residence; (c) For non-Jackson Class members who receive Community Living Services, at least every other month, one of the face-to-face visits shall occur in the individual's residence; (d) For adults who are not Jackson Class members and who do not receive Community Living Services, at least one face-to-face visit per quarter shall be in his or her home; (e) If concerns regarding the health or safety of the individual are documented during monitoring or assessment activities, the Case Manager shall immediately notify appropriate supervisory personnel within the Provider Agency and document the concern. If the reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office and/or the Division of Health Improvement (DHI) as appropriate to the nature of the concern. Unless the nature of the concern is urgent, no more than fifteen (15) working days shall be allowed for remediation or development of an acceptable plan of remediation. This does not preclude the Case Managers' obligation to report abuse, neglect or exploitation as required by New Mexico Statute. (f) Service monitoring for children: When a parent chooses fewer than twelve (12) annual units of case management, the Case Manager will inform the parent of the parent's			

responsibility for the monitoring and evaluation activities during the months he or she does not receive case management services, (g) It is appropriate to conduct face-to-face visits with the individual both during the time the individual is receiving a service and during times the individual is not receiving a service. The preferences of the individual shall be taken into consideration when scheduling a visit. Visits may be scheduled in advance or be unannounced visits depending on the nature of the need in monitoring service delivery for the individual. (h) Communication with IDT members: Case Managers shall facilitate and maintain communication with the individual or his or her representative, other IDT members, providers and other relevant parties to ensure the individual receives maximum benefit of his or her services. Case Managers need to ensure that any needed adjustments to the service plan are made, where indicated. Concerns identified through communication with teams that are not remedied within a reasonable period of time shall be reported in writing to the respective regional office and/or the Division of Health Improvements, as appropriate to the concerns.			

Tag # 4C15.1 - QA Requirements - Annual / Semi-Annual Reports & Provider Semi - Annual / Quarterly Reports	Standard Level Deficiency		
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: 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. 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. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 4 (CMgt) 2. Service Requirements: 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. 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:	Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 4 of 15 individuals. Review of the Agency individual case files revealed no evidence of quarterly/bi-annual reports for the following: • **Supported Living Quarterly Reports:** ◦ Individual #15 – None found for 7/2014 – 10/2014 and 1/2015 – 7/2015. • **Customized Community Supports Semi-Annual Reports:** ◦ Individual #6 – None found for 8/2014 – 7/2015. *(Term of ISP 8/2014 – 7/2015).* • **Community Integrated Employment Semi-Annual Reports:** ◦ Individual #6 – None found for 8/2014 – 7/2015. *(Term of ISP 8/2014 – 7/2015).* • **Speech Therapy Semi - Annual Progress Reports:** ◦ Individual #2 – None found for 9/2014 – 3/2015. ◦ Individual #3 – None found for 1/2015 – 6/2015. • **Occupational Therapy Semi - Annual Progress Reports:** ◦ Individual #15 – None found for 1/2015 – 7/2015. • **Nursing Quarterly Reports:**	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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 DDSD 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: **D. Monitoring And Evaluation of Service Delivery:** 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. 5. The Case Manager must ensure at least quarterly that: 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 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	◦ Individual #15 – None found for 7/2014 – 7/2015.		

and/or Customized Community Supports (day services), and who have such plans. 6. The Case Managers will report all suspected abuse, neglect or exploitation as required by New Mexico Statutes; 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. 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: a. Submit the DDSD Regional Office Request for 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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 IV**. **CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS** **C**. **Quality Assurance Requirements:** Case Management Provider Agencies will use an Internal Quality Assurance and Improvement Plan that must be submitted to and reviewed by the Statewide Case Management Coordinator, that shall include but is not limited to the following: (1) Case Management Provider Agencies are to: (a) Use a formal ongoing monitoring protocol that provides for the evaluation of quality, effectiveness and continued need for services and supports provided to the individual. This protocol shall be written and its implementation documented. (b) Assure that reports and ISPs meet required timelines and include required content. (c) Conduct a quarterly review of progress reports from service providers to verify			

that the individual's desired outcomes and action plans remain appropriate and realistic. (i) If the service providers' quarterly reports are not received by the Case Management Provider Agency within fourteen (14) days following the end of the quarter, the Case Management Provider Agency is to contact the service provider in writing requesting the report within one week from that date. (ii) If the quarterly report is not received within one week of the written request, the Case Management Provider Agency is to contact the respective DDSD Regional Office in writing within one business day for assistance in obtaining required reports. (d) Assure at least quarterly that Crisis Prevention/Intervention Plans are in place in the residence and at the Provider Agency of the Day Services for all individuals who have chronic medical condition(s) with potential for life threatening complications and/or who have behavioral challenge(s) that pose a potential for harm to themselves or others. (e) Assure at least quarterly that a current Health Care Plan (HCP) is in place in the residence and day service site for individuals who receive Community Living or Day Services and who have a HAT score of 4, 5, or 6. During face-to-face visits and review of quarterly reports, the Case Manager is required to verify that the Health Care Plan is being implemented.			

(f) Assure that Community Living Services are delivered in accordance with standards, including responsibility of the IDT Members to plan for at least 30 hours per week of planned activities outside the residence. If this is not possible due to the needs of the individual, a goal shall be developed that focuses on appropriate levels of community integration. These activities do not need to be limited to paid supports but may include independent or leisure activities appropriate to the individual. (g) Perform annual satisfaction surveys with individuals regarding case management services. A copy of the summary is due each December 10th to the respective DDSD Regional Office, along with a description of actions taken to address suggestions and problems identified in the survey. (h) Maintain regular communication with all providers delivering services and products to the individual. (i) Establish and implement a written grievance procedure. (j) Notify appropriate supervisory personnel within the Provider Agency if concerns are noted during monitoring or assessment activities related to any of the above requirements. If such concerns are not remedied by the Provider Agency within a reasonable mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office and/or DHI as appropriate to the nature of the concern. This does not preclude Case Managers' obligations to report abuse, neglect or			

exploitation as required by New Mexico Statute. (k) Utilize and submit the "Request for DDSD Regional Office Intervention" form as needed, such as when providers are not responsive in addressing a quality assurance concern. The Case Management Provider Agency is required to keep a copy in the individual's file. (2) Case Managers and Case Management Provider Agencies are required to promote and comply with the Case Management Code of Ethics: (a) Case Managers shall provide the individual/guardian with a copy of the Code of Ethics when Addendum A is signed. (b) Complaints against a Case Manager for violation of the Code of Ethics brought to the attention of DDSD will be sent to the Case Manager's supervisor who is required to respond within 10 working days to DDSD with detailed actions taken. DDSD reserves the right to forward such complaints to the IRC.			

Tag # 4C16 - Req. for Reports & Distribution of Doc.	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 4 (CMgt) 3. Agency Requirements** **L. Primary Record Documentation:** The Case Manager is responsible for maintaining required documentation for each individual served: 1. The Case Manager will provide reports and data as specified/requested by DDSD within the required time frames; 2. Case Managers will provide copies of the ISP to the Provider Agencies listed in the budget, and the individual and guardian (if applicable) within 14 days of the new ISP effective date; 3. Case Managers will provide copies of the ISP to the respective DDSD Regional Offices within 14 days of the new ISP effective date; 4. Copies of the ISP are distributed by the case manager to providers, the individual and guardian(s) and shall include any related ISP minutes, teaching and support strategies, individual specific training required, client rights and responsibilities, and revisions, if applicable; and Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS** **D. Case Manager Requirements for Reports and Distribution of Documents**	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 2 of 15 Individual: The following was found indicating the agency failed to provide a copy of the ISP within 14 days of the ISP Approval to the respective DDSD Regional Office, Provider Agencies, Individual and / or Guardian: **No Evidence found indicating ISP was distributed:** ° Individual #6: ISP was not provided to DDSD Regional Office ° Individual #13: ISP was not provided to DDSD Regional Office	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

(1) Case Managers will provide reports and data as specified/requested by DDSD within the required time frames. (2) Case Managers shall provide copies of the ISP to the Provider Agencies listed in the budget, and the individual and guardian (if applicable) within 14 days of ISP approval; (3) Case Managers shall provide copies of the ISP to the respective DDSD Regional Offices within 14 days of ISP approval. (4) Copies of the ISP given to providers, the individual and guardians shall include any related ISP minutes, provider strategies, individual specific training required, client rights and responsibilities, and revisions, if applicable. (5) At times, recommendations for further evaluations, screenings, diagnostics and/or treatments may be made to the IDT Members by various healthcare staff, consultants, various audit tools, the Supports and Assessments for Feeding and Eating (SAFE) Clinic, Transdisciplinary Evaluation and Support Clinic (TEASC) or other experts: (a) The IDT Members shall discuss these recommendations and a determination made if the IDT Members agree with the recommendations. (b) If the IDT Members concur with the recommendation, the ISP is required to be revised and follow-up shall be completed and documented in progress reports and, if applicable, in a revision to relevant therapy plans.			

(c) If the IDT Members, in their professional judgment, do not agree with the recommendation, the reasons for this shall be clearly documented in the Decision Justification document and filed by the Case Manager with the healthcare provider or consultant report/document in which the recommendation was made. (d) A copy of the Decision Justification document shall also is given to the residential provider (if any) and the guardian. (6) The individual's name and the date are required to be included on all pages of documents. All documents shall also include the signature of the author on the last page.			

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 #1A12 All Services Reimbursement (No Deficiencies)			

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 4 (CMgt) 3. Agency Requirements: 4. Reimbursement:**

A. Record Maintenance: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, nature of services, and length of a session of service billed.

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

    a. Date, start and end time of each service encounter or other billable service interval;

    b. A description of what occurred during the encounter or service interval; and

    c. The signature or authenticated name of staff providing the service.

Billing for Case Management services was reviewed for 15 of 15 individuals. *Progress notes and billing records supported billing activities for the months of July, August and September 2015.*

Date: February 19, 2016

To: Elizabeth Sandoval, Social Work Supervisor
Provider: New Mexico Behavioral Health Institute
Address: 700 Friedman Avenue
State/Zip: Las Vegas, New Mexico 87701

E-mail Address: Elizabeth.Sandoval2@state.nm.us

CC: Corrine Dominguez, Director Community Based Services
E-mail Address: Corrine.Dominguez@state.nm.us

CC: Dr. Troy Jones, Executive Director/Administrator
E-mail Address: Troy.Jones@state.nm.us

Region: Northeast
Survey Date: October 30 – November 4, 2015
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: ***2007 & 2012:*** Case Management

Survey Type: Routine

Dear Ms. Sandoval;

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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