

Date: June 1, 2016

To: Gabriela B. Ramos, Executive Director
Provider: Carino Case Management, Inc.
Address: 2701 San Pedro NE, Suite 10
State/Zip: Albuquerque, NM 87110

E-mail Address: gbramos@comcast.net

Region: Metro
Survey Date: April 29 – May 4, 2016
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: 2007 & 2012 Case Management
Survey Type: Routine

Team Leader: Chris Melon, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Nicole Brown, MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Corrina Strain, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jesus Trujillo, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau.

Dear Ms. Ramos,

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

DIVISION OF HEALTH IMPROVEMENT

5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
(505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

QMB Report of Findings – Carino Case Management, Inc. – Metro Region – April 29 – May 4, 2016

Survey Report #: Q.16.4.DDW.D2326.5.RTN.01.16.153

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.

During the exit interview of your on-site survey Attachment A on the Plan of Correction Process was provided to you. Please refer to 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:

- 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? (i.e. file reviews, periodic check with checklist, 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)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORI, etc.)

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,

Chris Melon, MPA

Chris Melon, MPA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: May 2, 2016

Present: **Carino Case Management, Inc.**
Linda Boddy, Case Manager
Jo Brewer, Case Manager
Rebecca Taylor, Case Manager
Margaret Terry, Case Manager

DOH/DHI/QMB
Chris Melon, MPA, Team Lead/Healthcare Surveyor
Crystal Lopez – Beck, BA, QMB Deputy Bureau Chief
Nicole Brown, MBA, Healthcare Surveyor
Corrina Strain, RN, Healthcare Surveyor
Jesus Trujillo, RN, Healthcare Surveyor

Exit Conference Date: May 4, 2016

Present: **Carino Case Management, Inc.**
Linda Boddy, Case Manager
Jo Brewer, Case Manager
Lorraine Kubik, Case Manager

DOH/DHI/QMB
Chris Melon, MPA, Team Lead/Healthcare Surveyor
Nicole Brown, MBA, Healthcare Surveyor
Corrina Strain, RN, Healthcare Surveyor
Jesus Trujillo, RN, Healthcare Surveyor

Administrative Locations Visited	Number:	1
Total Sample Size	Number:	30 3 - <i>Jackson</i> Class Members 27 - <i>Non-Jackson</i> Class Members
Persons Served Records Reviewed	Number:	30
Total Number of <i>Secondary Freedom of Choices</i> Reviewed:	Number:	125
Case Managers Interviewed	Number:	9
Case Mgt Personnel Records Reviewed	Number:	9
Administrators Interviewed	Number:	1

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.

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.

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 the following Service Domains.

Case Management Services (Four Service Domains):

- Plan of Care: ISP Development & Monitoring
- Level of Care
- Qualified Providers
- Health, Safety and Welfare

Community Living Supports / Inclusion Supports (Three Service Domains):

- Service Plans: ISP Implementation
- Qualified Provider
- Health, Safety and Welfare

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: Plan of Care ISP Development & Monitoring

Condition of Participation:

1. **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:

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

Service Domain: Level of Care

Condition of Participation:

3. **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.

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: Service Plan: ISP Implementation

Condition of Participation:

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

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.

**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: Carino Case Management, Inc. - Metro Region
Program: Developmental Disabilities Waiver
Service: 2012: Case Management
 2007: Case Management
Monitoring Type: Routine Survey
Survey Date: April 29 – May 4, 2016

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 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.			
Tag # 4C01.2 Case Management Services – Supports Intensity Scale	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</p> <p>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.</p> <p>Case Management services are person-centered and intended to support individuals in pursuing their desired life outcomes while</p>	<p>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 4 of 30 individuals.</p> <p>Review of documentation found the following were not current or not found:</p> <ul style="list-style-type: none"> • Supports Intensity Scale: Individual #2 last completed on 2/16/2012. Not completed every 3 years as required. • Supports Intensity Scale: Individual #4 last completed on 3/23/2012. Not completed every 3 years as required. • Supports Intensity Scale: Individual #20 last completed on 8/8/2011. Not completed every 3 years as required. 	<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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

QMB Report of Findings – Carino Case Management, Inc. – Metro Region – April 29 – May 4, 2016

<p>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.</p> <p>New Mexico Developmental Disabilities Waiver Supports Intensity Scale® (SIS) Reassessment Approval Policy effective May 24, 2013</p> <p>II. POLICY STATEMENT</p> <p>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 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.</p> <p>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</p> <p>II. PURPOSE OF PROCEDURE</p>	<ul style="list-style-type: none"> • Supports Intensity Scale: Individual #22 last completed on 7/21/2011. Not completed every 3 years as required. 		
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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 # 4C15.1 - QA Requirements - 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 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.</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>Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 1 of 30 individuals.</p> <p>Review of the Agency individual case files revealed no evidence of quarterly/bi-annual reports for the following:</p> <ul style="list-style-type: none"> • Physical Therapy Semi - Annual Progress Reports: <ul style="list-style-type: none"> ◦ Individual #28 – None found for 9/2015 – 3/2016. (Term of ISP 9/15/15 – 9/14/16) 	<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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</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> <ul style="list-style-type: none"> 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. 			
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<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 DDS Regional Office:</p> <ul style="list-style-type: none"> a. Submit the DDS 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. <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</p>			
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<p>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>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</p> <p>C. Quality Assurance Requirements: Case Management Provider Agencies will use an Internal Quality Assurance and Improvement Plan that must be submitted to and reviewed by the Statewide Case Management Coordinator, that shall include but is not limited to the following:</p> <p>(1) Case Management Provider Agencies are to:</p> <ul style="list-style-type: none"> (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. 			
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<ul style="list-style-type: none"> (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 DDS 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 			
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<p>individual, a goal shall be developed that focuses on appropriate levels of community integration. These activities do not need to be limited to paid supports but may include independent or leisure activities appropriate to the individual.</p> <p>(g) Perform annual satisfaction surveys with individuals regarding case management services. A copy of the summary is due each December 10th to the respective DDS Regional Office, along with a description of actions taken to address suggestions and problems identified in the survey.</p> <p>(h) Maintain regular communication with all providers delivering services and products to the individual.</p> <p>(i) Establish and implement a written grievance procedure.</p> <p>(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 DDS Regional Office and/or DHI as appropriate to the nature of the concern. This does not preclude Case Managers' obligations to report abuse, neglect or exploitation as required by New Mexico Statute.</p> <p>(k) Utilize and submit the "Request for DDS Regional Office Intervention" form as needed, such as when providers are not responsive in addressing a quality assurance concern. The Case Management</p>			
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<p>Provider Agency is required to keep a copy in the individual's file.</p> <p>(2) Case Managers and Case Management Provider Agencies are required to promote and comply with the Case Management Code of Ethics:</p> <p>(a) Case Managers shall provide the individual/guardian with a copy of the Code of Ethics when Addendum A is signed.</p> <p>(b) Complaints against a Case Manager for violation of the Code of Ethics brought to the attention of DDSD will be sent to the Case Manager's supervisor who is required to respond within 10 working days to DDSD with detailed actions taken. DDSD reserves the right to forward such complaints to the IRC.</p>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>CMS Assurance – 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.</p>			
<p>Tag # 1A26 Consolidated On-line Registry / Employee Abuse Registry</p>	<p>Standard Level Deficiency</p>		
<p>NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or</p>	<p>Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 1 of 9 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #206 – Date of hire 3/1/2016. Completed on 3/28/2016. 	<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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	

<p>exploitation of a person receiving care or services from a provider.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.</p> <p>F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.</p>			
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<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>Chapter 1.IV. General Provider Requirements. D. Criminal History</p> <p>Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.</p>			
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Tag # 4C14 Administrative Requirements	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 (Case Mgt) Chapter 4. 3. Agency Requirements C. Programmatic Requirements:</p> <p>1. Case Management Provider Agencies shall have an established system for tracking key steps and timelines in establishing eligibility, service planning, budget approval and distribution of records to IDT Members.</p> <p>2. Case Management Agencies shall maintain at least one (1) office in each region served by the agency that meets Americans with Disabilities Act (ADA) accessibility requirements and that includes:</p> <p>a. A 24-hour local telephone answering system. The Case Management Provider Agency must return all calls not later than 5:00 p.m. the following business day; the answering system must indicate regular office hours and expected response time by the end of the following business day;</p> <p>b. If case managers use their home office or cell number as primary contact for the individuals on their caseload, their voicemail must indicate that they return calls by 5 p.m. the next business day, as well as the main number for the case management agency;</p> <p>c. An operational fax machine;</p> <p>d. Internet and e-mail access, including use of a secure email systems (Scomm) for client</p>	<p>Based on record review the Agency's Procedure Handbook regarding on-call did not follow established Programmatic Requirements.</p> <p>Evidence found indicated Carino Case Management, Inc.'s Procedure Handbook for On Call states, "Program manager answers telephones M-F 8a-5p except during holidays, days that the agency is closed, or if she is in a meeting or a home visit. Her telephone is able to take messages and the message informs people that we will get back to them within 48 hours of their call." Per DDSD Requirements, the Case Management Provider Agency must return all calls no later than 5:00 p.m. the following business day.</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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>identifying information, for every Case Manager employed or subcontracted;</p> <p>e. Client records for each individual served by the Provider Agency consistent with DDSD Consumer Record Requirements and that are stored on site, in compliance with HIPAA requirements;</p> <p>f. A meeting room that can accommodate IDT Members meetings comfortably;</p> <p>g. An area where a Case Manager may meet privately with an individual;</p> <p>h. A separate physical space and entrance, if the office is connected to a residence; and</p> <p>i. Exceptions to the above may be granted in writing by DDSD based on circumstances and needs of the service system. Requests for such exceptions shall be submitted to the Statewide Coordinator of the Case Management Unit of DDSD in writing with appropriate justification.</p> <p>A. Adherence to Requirements: Case Management Provider Agencies and their staff/sub-contractors are required to adhere to all requirements communicated to them by DDSD, including participation in the Therap system for health assessment and health tracking functions for individuals they serve, attendance at mandatory meetings, mandated trainings and technical assistance sessions</p>			
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Tag # 4C17 Case Manager Qualifications - Required Training	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 4 (CMgt) 3. Agency Requirements: C. Programmatic Requirements: H. Training:</p> <p>1. Within specified timelines, Case Managers shall meet the requirements for training as specified in the DDSD Policy T-002: Training Requirements for Case Management Staff Policy. All Case Management Provider Agencies are required to report personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001...</p> <p>2. All Case Managers are required to understand and to adhere to the Case Manager Code of Ethics.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Case Management Agency Staff Policy - Eff. March 1, 2007 II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified case managers.</p> <p>B. Case management staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</p>	<p>Based on record review, the Agency did not ensure that Training requirements were met for 1 of 9 Case Managers.</p> <p>Review of Case Manager training records found no evidence of the following required DOH/DDSD trainings being completed:</p> <ul style="list-style-type: none"> • Pre-Service Part One (#206) • Pre-Service Part Two (#206) 	<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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>	

<p>C. Case management staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p> <p>D. In addition to the applicable requirements described in policy statements B – C (above), case managers and case management supervisors shall complete DDS-approved core curriculum training...</p> <p>E. Substitutes shall comply with the training requirements of the staff for whom they are substituting.</p> <p>F. To complete a core curriculum-training course, trainees shall achieve 100% competency rating during the competency verification process.</p>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>Service Domain: Health 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.</p>			
<p>Tag # 1A03 CQI System</p>	<p>Standard Level Deficiency</p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 (Case Mgt) Chapter 4. 3. Agency Requirements M. Quality Assurance/Quality Improvement (QA/QI) Activities:</p> <p>1. QA/QI Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities:</p> <p>a. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working;</p> <p>b. Implementing a QA/QI Committee: The QA/QI committee shall convene on at least a quarterly</p>	<p>Based on record review, the Agency did not develop and implement a Continuous Quality Management System.</p> <p>Review of the Agency’s Continuous Quality Improvement Plan provided during the on-site survey did not contain the components required by Standards.</p> <p>The Agency’s CQI Plan did not contain the following components:</p> <ul style="list-style-type: none"> i. Implementation of the ISP, including the extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration and frequency specified in the ISP, as well as the effectiveness of such implementation as indicated by achievement of outcomes; ii. Timeliness of document submission, including the LOC,ISP, and Allocation Reporting Forms; iii. Patterns in reportable incidents; and iv. Results of improvement actions taken in previous quarters. 	<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 effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>	<p> </p>

<p>basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA meeting shall be documented;</p> <p>c. The QA review should address at least the following:</p> <ul style="list-style-type: none"> i. Implementation of the ISP, including the extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration and frequency specified in the ISP, as well as the effectiveness of such implementation as indicated by achievement of outcomes; ii. Timeliness of document submission, including the LOC,ISP, and Allocation Reporting Forms; iii. Analysis of General Events Reporting data; iv. Compliance with Caregivers Criminal History Screening requirements; v. Compliance with Employee Abuse Registry requirements; vi. Compliance with DDSD training requirements; vii. Patterns in reportable incidents; and viii. Results of improvement actions taken in previous quarters. <p>2. The Case Management provider agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report</p>			
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<p>must be submitted to the relevant DDSD Regional Office. The report will summarize:</p> <ul style="list-style-type: none"> a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's Quality Improvement plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and g. Significant program changes. h. Effectiveness and timeliness of document submission, including the LOC, ISP, and Allocation Reporting Forms. i. Effectiveness and timeliness of the allocation process. <p>NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS: F. Quality assurance/quality improvement program for community-based service providers: The community-based service provider shall establish and implement a quality improvement</p>			
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<p>program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's 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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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>Service Domain: Medicaid Billing/Reimbursement – <i>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</i></p>			
<p>TAG #1A12 All Services Reimbursement (No Deficiencies)</p>			
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 4 (CMgt) 3. Agency Requirements: 4. Reimbursement:</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> 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. <p>Billing for Case Management services was reviewed for 30 of 30 individuals. <i>Progress notes and billing records supported billing activities for the months of January, February, and March 2016.</i></p>			

Date: August 17, 2016

To: Gabriela B. Ramos, Executive Director
Provider: Carino Case Management, Inc.
Address: 2701 San Pedro NE, Suite 10
State/Zip: Albuquerque, NM 87110

E-mail Address: gbramos@comcast.net

Region: Metro
Survey Date: April 29 – May 4, 2016
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: 2007 & 2012 Case Management
Survey Type: Routine

Dear Ms. Ramos,

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

Q.16.4.DDW.D2326.5.RTN.09.16.230