Date: October 7, 2016

To: Carrie Lyon, Co-Director
Provider: Sun Country Case Management
Address: 133 Wyatt Drive # 4
State/Zip: Las Cruces, New Mexico 88005

E-mail Address: carriel@sccmsllc.com

CC: Natasha Rackoff Ruiz, Co-Director
Address: 133 Wyatt Drive # 4
State/Zip: Las Cruces, New Mexico 88005

E-Mail Address: natashar@sccmsllc.com

Region: Southwest
Survey Date: September 2 – 9, 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: Barbara Kane, BAS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau and Corrina Strain, RN, BSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau.

Dear Ms. Lyon;

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

Determination of Compliance:

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

Partial Compliance with Conditions of Participation

The following tags are identified as Condition of Participation Level Deficiencies:

- Tag # 1A28.1 - Incident Mgt. System - Personnel Training

This determination is based on non-compliance with one or more CMS waiver assurances at the Condition of Participation level as well as Standard level deficiencies identified in the attached QMB Report of Findings 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.

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

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

Attention: Lisa Medina-Lujan
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:	September 6, 2016	
Present:	**Sun Country Case Management** Bernadette Gamboa, Case Manager Carrie Lyon, Case Manager/Co-Director Mandy Mertz, Case Manager Geysi Zuniga, Quality Assurance **DOH/DHI/QMB** Chris Melon, MPA, Team Lead/Healthcare Surveyor Barbara Kane, BAS, Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor Corrina Strain, RN, BSN, Healthcare Surveyor	
Exit Conference Date:	September 9, 2016	
Present:	**Sun Country Case Management** Melissa Campa, Case Manager Bernadette Gamboa, Case Manager Andi Gonzales, Case Manager Sofia Hughes, Case Manager Carrie Lyon, Case Manager/Co-Director Mandy Mertz, Case Manager Tasha Rackoff Ruiz, Case Manager/Co-Director Joyce Sahker, Case Manager **DOH/DHI/QMB** Chris Melon, MPA, Team Lead/Healthcare Surveyor Barbara Kane, BAS, Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor Corrina Strain, RN, BSN, Healthcare Surveyor **DDSD - Southwest Regional Office** Cheryl Dunfee, Case Manager Coordinator	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	30 3 - *Jackson* Class Members 27 - Non-*Jackson* Class Members
Persons Served Records Reviewed	Number:	30
Total Number of *Secondary Freedom of Choices* Reviewed:	Number:	150
Case Managers Interviewed	Number:	11
Case Mgt. Personnel Records Reviewed	Number:	11
Administrators Interviewed	Number:	2 (*2 Administrators also perform duties as Case Managers*)

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.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

Attachment B

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

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and 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 and/or 6 or more Condition of Participation level deficiencies overall, as well as widespread Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

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: **Sun Country Case Management - Southwest Region**
Program: Developmental Disabilities Waiver
Service: 2012: Case Management
2007: Case Management
Monitoring Type: Routine Survey
Survey Date: **September 2 – 9, 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 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; 6/15/2015 **CHAPTER 4 (CMgt) I. Case Management Services: 1. Scope of Services: S.** Maintain a complete record for the individual's DDW services, as specified in DDSD Consumer Records Requirements Policy; **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.	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 18 of 30 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • **Current Emergency & Personal Identification Information** ◦ None Found (#30) ◦ Did not contain Physician's Information (#4) ◦ Did not contain Pharmacy Information (#4) • **Annual ISP** ◦ Not Found (#30) • ISP Assessment Checklist Appendix 1 (#6, 8, 15, 30)	**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?)***: →** **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?)***: →**	

H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. 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);	• **ISP Signature Page** ◦ None Found (#30) ◦ Not Fully Constituted IDT *(No evidence of guardian involvement)* (#5) • Addendum A (#30) • Individual Specific Training Section (ISP) (#30) • **Assistive Technology Inventory List** ◦ Individual #5- As indicated by the Health and Safety section of ISP the individual is required to an inventory list. No evidence of inventory found. ◦ Individual #14- As indicated by the Speech Language Pathologist, the individual is required to an inventory list. No evidence of inventory found. ◦ Individual #29- As indicated by the Health and Safety section of ISP the individual is required to an inventory list. No evidence of inventory found. • **ISP Teaching & Support Strategies** ◦ Individual #4 - TSS not found for the following Action Steps: ◦ *Live Outcome Statement:* ➢ "…will check to see if it is safe to cross the street." ◦ *Work/Learn Outcome Statement:* ➢ "…will sit for at least 5 minutes to see the birds or ducks." ◦ *Fun/Relationship Outcome Statement:* ➢ "…will build the item of his choice."		

(3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the 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 #5 - TSS not found for the following Action Steps:* ◦ Live Outcome Statement: ➢ "…will discover and try new recipes." ➢ "…will add her favorites to cookbook." ◦ Fun/Relationship Outcome Statement: ➢ "…will initiate one activity per month." ◦ *Individual #6 - TSS not found for the following Action Steps:* ◦ Work/Learn Outcome Statement: ➢ "…will follow the assigned task list." ◦ Fun/Relationship Outcome Statement: ➢ "…will participate in a dance activity." ◦ *Individual #7 – No indication as to whether a TSS is required or not required for the following Action Steps:* ◦ Fun/Relationship Outcome Statement: ➢ "…will purchase the device of her choice." ➢ "…will practice using her device." ◦ *Individual #10 – No indication as to whether a TSS is required or not required for the following Action Step:* ◦ Fun/Relationship Outcome Statement: ➢ "…will talk about what she looked at with staff." ◦ *Individual #11 - TSS not found for the following Action Steps:* ◦ Live Outcome Statement: ➢ "Choose a project." ➢ "Gather needed material."		

	➢ "Complete the project." ◦ Fun/Relationship Outcome Statement: ➢ "Go to the library." ◦ *Individual #13 - TSS not found for the following Action Steps:* ◦ Live Outcome Statement: ➢ "…will learn at least 5 food items in each category." ➢ "…will create a menu once a week." ◦ *Individual #15 - TSS not found for the following Action Steps:* ◦ Live Outcome Statement: ➢ "…will complete basic cat care needs/chores." ➢ "…will keep her apartment clean and organized." ➢ "…will follow specific routines using visual cues to complete her daily hygiene routine." ➢ "…will dress appropriate for the weather." ➢ "…will plan and prepare food." ◦ Work/Learn Outcome Statement: ➢ "If…needs time off, she will follow appropriate protocols." ◦ Fun/Relationship Outcome Statement: ➢ "…will research and participate in her choice of community activity."		

	◦ Individual #18 - TSS not found for the following Action Steps: ◦ *Live Outcome Statement:* ➢ "…will collect recycling." ◦ Fun/Relationship Outcome Statement: ➢ "…will select a new activity to attend in the community." ◦ *Individual #20 – No indication as to whether a TSS is required or not required for the following Action Steps:* ◦ Work/Learn Outcome Statement: ➢ "…will research/plan activities in the community." ➢ "…will make arrangement to attend activities." ➢ "…will attend/participate in the activities in the community." ◦ *Individual #21 - TSS not found for the following Action Steps:* ◦ Fun/Relationship Outcome Statement: ➢ "…will go bowling and use the ramp." ➢ "…will attend a sporting event." ◦ *Live Outcome Statement:* ➢ "…will research and try new recipes." ➢ "…will add favorite to cookbook." ◦ Work/Learn Outcome Statement: ➢ "…will volunteer for the Salvation Army." ◦ Individual #24 - TSS not found for the following Action Steps: ◦ *Live Outcome Statement:* ➢ "…will purchase movie/DVD."		

	◦ Work/Learn Outcome Statement: ➢ "…will use task list schedule to identify precautions for each task on her own." ◦ Fun/Relationship Outcome Statement: ➢ "…will choose and complete a project and place in portfolio binder." ◦ Individual #27 – TSS not found for the following Action Steps: ◦ *Live Outcome Statement:* ➢ "…will assist with choosing a display." ◦ *Work/Learn Outcome Statement:* ➢ "…will use dual communication switch to tell about her pictures." *(Note: Per ISP both "yes" and "no" were checked for Teaching and Support Strategies for Live and Work/Learn Outcomes.)* Individual #30 - TSS not found: During the onsite survey the individual's current ISP was requested, however, as of September 9, 2016, the individual's current ISP was not provided. Surveyors were unable to determine if Teaching and Support Strategies were required for current Action Steps. • Positive Behavior Support Plan (#8, 21) • Behavior Crisis Intervention Plan (#21) • Speech Therapy Plan (#14, 30) • Occupational Therapy Plan (#14, 30) • Physical Therapy Plan (#30)		

	• Electronic Comprehensive Health Assessment Tool (#6, 10, 14) • **Health Care Plans** • *Alcohol Use* ◦ Individual #13 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Body Mass Index* ◦ Individual #10 - As indicated by the IST section of ISP, the individual is required to have a plan. No evidence of plan found. • *Bowel and Bladder* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Constipation* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Communication/Vision/Hearing* ◦ Individual #30 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Falls* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Hydration*		

	◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. ◦ Individual #30 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Level of Participation* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Neuro Device* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Paralysis* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Seizures* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Skin and Wound* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found.		

	• *Spasticity/ Contractures* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • **Medical Emergency Response Plans** • *Anxiety* ◦ Individual #29 - According to the IST section of the ISP, the individual is required to have a plan. No evidence of plan found. • *Aspiration* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Falls* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Neurological* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Paralysis* ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • *Respiratory* ◦ Individual #4 - According to Electronic Comprehensive Health Assessment Tool,		

	the individual is required to have a plan. No evidence of plan found. • *Seizures* ◦ Individual #4 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. ◦ Individual #27 - According to Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of plan found. • **Special Health Care Needs:** • *Comprehensive Aspiration Risk Management Plan (CARMP)* ◦ Individual #29 - As indicated by Individual Specific Training section of the ISP, the individual is required to have a CARMP. No evidence of CARMP found. ◦ Individual #30 - As indicated by collateral documentation reviewed, the individual is required to have a CARMP. No current CARMP found. • **Nutritional Evaluation** ◦ Individual #11 - As indicated by documentation reviewed evaluation was completed on 3/21/2015. Follow-up was to be completed in 4 months. No documented evidence of follow-up being completed was found. ◦ Individual #21 - As indicated by documentation reviewed evaluation was completed on 5/17/2016. Follow-up was to be completed in 2 months. No documented evidence of follow-up being completed was found.		

	• **Nutritional Plan** ° Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. ° Individual #15 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • **Dental Exam** ° Individual #4 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found. ° Individual #6 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found. ° Individual #10 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No documented evidence of exam was found. ° Individual #14 – As indicated by the documentation reviewed, exam was to be completed 1/2016. No documented evidence was found to verify visit was completed. ° Individual #21 – As indicated by the documentation reviewed, exam was completed on 8/11/2015. Follow-up was to be completed in 3 months. No documented evidence of the follow-up being completed was found. ° Individual #29 - As indicated by the DDSD file matrix Dental Exams are to be		

	conducted annually. No documented evidence of exam was found. • **Auditory Exam** ° Individual #14 - As indicated by the documentation reviewed, exam was to be completed in 1/2016. No documented evidence was found to verify visit was completed. ° Individual #21 - As indicated by the documentation reviewed, exam was completed on 4/23/2015. Follow-up was to be completed in 12 months. No documented evidence of the follow-up being completed was found. • **Vision Exam** ° Individual #4 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No documented evidence of exam was found. ° Individual #14 - As indicated by the documentation reviewed, exam was scheduled for 7/1/2015. No documented evidence was found to verify visit was completed. ° Individual #21 - As indicated by the documentation reviewed, the exam was to be completed on 10/21/2015. No documented evidence of the exam being completed was found. ° Individual #30 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No documented evidence of exam was found. • **Clinical Breast Exam**		

	◦ Individual #27 - As indicated by the documentation reviewed, the exam was to be completed on 6/2/2015. No documented evidence of the exam being completed was found. • **Pap Smear Exam** ◦ Individual #27 - As indicated by the documentation reviewed, the exam was to be completed on 6/2/2015. No documented evidence of the exam being completed was found. • **Mammogram Exam** ◦ Individual #27 - As indicated by the documentation reviewed, the exam was to be completed on 6/2/2015. No documented evidence of the exam being completed was found. • **Colonoscopy** ◦ Individual #15 - As indicated by the documentation reviewed, the exam was completed on 8/3/2009. No documented evidence of the exam being completed was found. ▪ **Lipid Panel** ◦ Individual #20 - As indicated by the documentation reviewed, lab work was ordered on 8/4/2016. No documented evidence was found to verify it was completed. • **Blood Levels** ◦ Individual #27 - As indicated by the documentation reviewed, lab work was ordered on 3/10/2016. No documented evidence found to verify it was completed. • **Influenza Vaccine**		

	◦ Individual #27 - As indicated by the documentation reviewed, the vaccine was ordered on 3/10/2016. No documented evidence of the exam being completed was found. • Person Centered Assessment (#11, 15) • Occupational Therapy Evaluation (#14, 29) • **Decision Consultation Forms** ◦ Individual #3 - As indicated by the documentation reviewed, the IDT has Decision Justification Forms for *Dental* and *Vision* exams. Per the March 15, 2015 DDSD memo regarding Decision Consultation and Team Justification process and forms, a Decision Consultation Form is to be used for all medically related topics.		

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; 6/15/2016 **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 30 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Primary Freedom of Choice (#5)	**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?)*: → **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?)*: →	

Tag # 4C07 Individual Service Planning	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 4 (CMgt) 1. Scope of Services:** **G.** Ensure the development of targeted, realistic desired outcomes and action plans with measurable action steps and relevant useful TSS by the IDT; **I.** Coordinate and advocate for the revision of the ISP when desired outcomes are completed or not achieved within expected timeframes; **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… **7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS:** Each ISP shall contain…C. Outcomes: (1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in	Based on record review the Agency did not ensure Case Managers developed realistic and measurable desired outcomes for the individual as identified in the ISP which includes the individual's long-term vision, summary of strengths, preferences and needs, desired outcomes and an action plan for 1 of 30 Individuals. The following was found with regards to ISP Outcomes: Individual #30: During the onsite survey the individual's current ISP was requested, however, as of September 9, 2016 the individual's current ISP was not provided. Surveyors were unable to determine if all Outcomes were measurable and if all Outcome Action Steps were skilled based, worked at increasing independence and were relevant.	**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?)*: → **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?)*: →	

communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP. (2) Outcomes planning shall be implemented in one or more of the four “life areas” (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS E**. **Individualized Service Planning and Approval:** (1) Individualized service planning is developed through a person-centered planning process in accordance with the rule governing ISP development (7.26.5 NMAC). A person-centered planning process shall be used to develop an ISP that includes: (a) Realistic and measurable desired outcomes for the individual as identified in the ISP which includes the individual’s long-term vision, summary of strengths, preferences and needs, desired outcomes and an action plan and is: (i) An ongoing process, based on the individual’s long-term vision, and not a one-time-a-year event; and			

(ii) Completed and implemented in response to what the IDT members learn from and about the person and involves those who can support the individual in achieving his or her desired outcomes (including family, guardians, friends, providers, etc.). (2) The Case Manager will ensure the ongoing assessment of the individual's strengths, needs and preferences and use this information to inform the IDT members and guide the development of the plan.			

Tag # 4C07.1 Individual Service Planning – Paid Services	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 4 (CMgt) 1. Scope of Services:** **G.** Ensure the development of targeted, realistic desired outcomes and action plans with measurable action steps and relevant useful TSS by the IDT; **I.** Coordinate and advocate for the revision of the ISP when desired outcomes are completed or not achieved within expected timeframes; **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. 2. The ISP is developed through a person-centered planning process in accordance with the rules governing ISP development [7.26.5 NMAC] and includes… **7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS:** Each ISP shall contain…C. Outcomes: (1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may	Based on record review the Agency did not ensure Case Managers developed outcomes for the individual for each paid service for 3 of 30 Individuals. The following was found with regards to ISP Outcomes: Individual #8: • Individual has no Customized Community Support Service per current and approved budget. Therefore, the Live Outcome Action Step of, "…will tell his family how his day was at Dayhab" cannot be completed. Individual #29: • No Outcomes or DDSD exemption/decision justification found for Customized Community Supports (Individual) Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver." Individual #30: • During the onsite survey the individual's current ISP was requested, however, as of September 9, 2016 the individual's current ISP was not provided. Surveyors were unable to determine if all paid services were tied to Visions, Outcomes, Actions and/or Teaching and Support Strategies.	**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?)*: → **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?)*: →	

generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP. (2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS E. Individualized Service Planning and Approval:** (1) Individualized service planning is developed through a person-centered planning process in accordance with the rule governing ISP development (7.26.5 NMAC). A person-centered planning process shall be used to develop an ISP that includes: (a) Realistic and measurable desired outcomes for the individual as identified in the ISP which includes the individual's long-term vision, summary of strengths, preferences and needs, desired outcomes and an action plan and is: (i) An ongoing process, based on the individual's long-term vision, and not a one-time-a-year event; and			

(ii) Completed and implemented in response to what the IDT members learn from and about the person and involves those who can support the individual in achieving his or her desired outcomes (including family, guardians, friends, providers, etc.). (2) The Case Manager will ensure the ongoing assessment of the individual's strengths, needs and preferences and use this information to inform the IDT members and guide the development of the plan.			

Tag # 4C09 Secondary FOC	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 4 (CMgt) 2. Service Requirements C. Individual Service Planning: v.** Secondary Freedom of Choice Process: A. The Case Manager will obtain a current Secondary Freedom of Choice (FOC) form that includes all service providers offering services in that region; B. The Case Manager will present the Secondary FOC form for each service to the individual or authorized representative for selection of direct service providers; and C. At least annually, rights and responsibilities are reviewed with the recipients and guardians and they are reminded they may change providers and/or the types of services they receive. At this time, Case Managers shall offer to review the current Secondary FOC list with individuals and guardians. If they are interested in changing providers or service types, a new Secondary FOC shall be completed. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS: G.Secondary Freedom of Choice Process** (1) The Case Management Provider Agency will ensure that it maintains a current Secondary Freedom of Choice (FOC) form that includes all service providers offering services in that region.	Based on record review, the Agency did not maintain the Secondary Freedom of Choice documentation (for current services) and/or ensure individuals obtained all services through the Freedom of Choice Process for 2 of 30 individuals. Review of the Agency individual case files revealed 2 out of 150 Secondary Freedom of Choices were not found and/or not agency specific to the individual's current services: • **Secondary Freedom of Choice** ◦ Customized In-Home Supports (#20) ◦ Speech Therapy (#6)	**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?)*: → **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?)*: →	

(2) The Case Manager will present the Secondary FOC form to the individual or authorized representative for selection of direct service providers. (3) At least annually, at the time rights and responsibilities are reviewed, individuals and guardians served will be reminded that they may change providers at any time, as well as change types of services. At this time, Case Managers shall offer to review the current Secondary FOC list with individuals and guardians served. If they are interested in changing, a new FOC shall be completed.			

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; 6/15/2015 **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. 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**	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 1 of 30 individuals. The following item was not found: • Budget Worksheet Waiver Review Form or MAD 046 (#30)	**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?)*: → **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?)*: →	

(1) Case Management Providers are authorized by DDSD to approve ISPs and budgets (including initial, annual renewals and revisions) for all individuals except as 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; 6/15/2015 **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.	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 30 of 30 individuals. Review of the Agency's Individual Case Files revealed case managers were not using the required *Developmental Disability Support Division Case Manager Monthly Site Visit Form. (*#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30) When asked to provide a DDSD approval for utilization of an agency internal form, Co-Director #209 stated they had received an approval from DDSD, however, when asked, the agency was unable to provide the DDSD approval documentation. Per the DDSD Memo on New Monthly Site Visit Monitoring Forms dated June 17, 2010, "DDSD is requiring that all Case Management Agencies use these forms only. Previous agency adaptations of the Site Visit Form shall NOT be used. No changes may be made to these new Site Visit Forms, except that they may be formatted from "Landscape" to "Portrait", as long as there is similar space for documentation. The only exception to this is that Case Management Agencies using an electronic case management system, may continue using those systems, provided that the electronic fields in those systems include ALL questions from the new Site Visit Forms. A sample printout of the data fields must be sent to the Statewide CM Coordinator, for prior approval of use."	**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?)*: → **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?)*: →	

e. For non-Jackson Class members, who receive a Living Supports service, at least one face-to-face visit shall occur at the individual's home quarterly; and at least one face- to-face visit shall occur at the day program quarterly if the individual receives Customized Community Supports or Community Integrated Employment services. The third quarterly visit is at the discretion of the Case Manager. 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	**Review of the Agency individual case files revealed face-to-face visits were not being completed as required by standard (2 b, c & d) for the following individuals:** Individual #6 (Non-Jackson) • 1 home visit was noted between 10/2015 & 7/2016. ◦ July 22, 2016 – 11:30am – 1:00pm – Site visit. ◦ June 7, 2016 – 11:30am – 12:40pm - Site visit. ◦ May 24, 2016 – 10:00am – 11:30am – Site visit. ◦ April 26, 2016 – 1:30pm – 3:00pm – Site visit. ◦ March 24, 2016 – 2:30pm – 4:00pm – Site visit. ◦ February 26, 2016 – 3:30am – 4:45pm – Home visit. ◦ January 26, 2016 – 2:00pm – 2:30pm – Site visit. ◦ December, 2015 – 11:30am – 12:45pm – Site visit. ◦ November 20, 2015 – 10:30am – 11:45pm – Site visit. ◦ October 22, 2015 – 12:50pm – 2:30pm – Site visit. Individual #9 (Non-Jackson) • 2 site visits were noted between 8/2015 & 7/2016.		

Supports 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	◦ July 18, 2016 – 1:00pm – 2:00pm – Home visit. ◦ June 14, 2016 – 3:30pm – 4:30pm – Site visit. ◦ May 1, 2016 – 2:00pm – 2:45pm – Site visit. ◦ April 20, 2016 – 3:40pm – 5:00pm – Home visit. ◦ March 23, 2016 – 4:00pm – 5:30pm – Home visit. ◦ February 29, 2016 – 5:45pm – 6:45pm – Home visit. ◦ January 15, 2016 – 1:00pm – 2:00pm – Home visit. ◦ December 16, 2015 – 4:40pm – 6:10pm – Home visit. ◦ November 19, 2015 – 4:30pm – 5:30pm – Home visit. ◦ October 28, 2015 – 4:30pm – 6:00pm – Home visit. ◦ September 28, 2015 – 4:30pm – 6:00pm – Home visit. ◦ August 19, 2015 – 4:30pm – 6:00pm – Home visit. Individual #10 (Non-Jackson) • No home visits were noted between 1/2016 – 5/2016.		

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.	◦ June 27, 2016 – 4:30am – 6:00pm – Home visit. ◦ May 4, 2016 – 9:00am – 10:30am – Site visit. ◦ April 6, 2016 – 3:00pm – 4:00pm – Site visit. ◦ March 31, 2016 – 9:00am – 10:00am – Site visit. ◦ February 29, 2016 – 11:30am – 12:30pm – Site visit. ◦ January 26, 2016 – 3:00pm – 4:15pm – Site visit. Individual #14 (Non-Jackson) • No home visits were noted between 8/2015 & 7/2016. ◦ July 22, 2016 – 1:45pm – 3:00pm – Site visit. ◦ June 10, 2016 – 11:30am – 1:00pm – Site visit. ◦ May 26, 2016 – 1:40pm – 3:00pm – Site visit. ◦ April 11, 2016 – 11:00am – 12:30pm – Site visit. ◦ March 24, 2016 – 12:00pm – 1:30pm – Site visit. ◦ February 18, 2016 – 10:00am – 11:30am – Site visit.		

(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	◦ January 25, 2016 – 12:00pm – 1:30pm – Site visit. ◦ December 14, 2015 – 12:45pm – 2:00pm – Site visit. ◦ November 6, 2015 – 11:00am – 12:30pm – Site visit. ◦ October 27, 2015 – 12:50pm – 2:00pm – Site visit. ◦ September 4, 2015 – IDT Meeting – Site visit. ◦ August 26, 2015 – 12:30pm – 2:00pm – Site visit. Individual #19 (Non-Jackson) • 2 home visits were noted between 8/2015 & 7/2016. ◦ July 2, 2016 – 1:30pm – 3:00pm – Home visit. ◦ June 10, 2016 – 10:00am – 11:30am – Site visit. ◦ May 20, 2016 – 12:30pm – 1:30pm – Site visit. ◦ April 26, 2016 – 12:00pm – 1:00pm – Site visit. ◦ March 31, 2016 – 2:00pm – 3:00pm – Site visit. ◦ February 25, 2016 – 11:30am – 12:30pm – Site visit.		

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.	◦ January 18, 2016 – 3:30pm – 4:30pm – Site visit. ◦ December 3, 2015 – 2:00pm – 3:00pm – Site visit. ◦ November 13, 2015 – 11:30am – 12:30pm – Site visit. ◦ October 6, 2015 – 1:30pm – 2:30pm – Site visit. ◦ September 18, 2015 – 11:30am – 12:30pm – Home visit. ◦ August 6, 2015 – 12:00pm – 1:00pm – Site visit. Individual #29 (Non-Jackson) • No home visits were noted between 8/2015 & 7/2016. ◦ July 19, 2016 – 1:30pm – 2:30pm – Site visit. ◦ June 21, 2016 – 12:00pm – 1:00pm – Site visit. ◦ May 20, 2016 – 1:40pm – 3:00pm – Site visit. ◦ April 20, 2016 – 11:00am – 12:00pm – Site visit. ◦ March 8, 2016 – 11:30am – 12:30pm – Site visit. ◦ February 18, 2016 – 2:00pm – 3:00pm – Site visit.		

	◦ January 26, 2016 – 1:00pm – 5:00pm – Site visit. ◦ December 16, 2015 – 1:00pm – 2:15pm – Site visit. ◦ November 4, 2015 – 1:00pm – 2:30pm – Site visit. ◦ October 13, 2015 – 2:30pm – 3:30pm – Site visit. ◦ September 2, 2015 – 12:00pm – 1:00pm – Site visit. ◦ August 27, 2015 – 1:00pm – 2:00pm – Site visit. Individual #30 (Jackson) • No site visits were noted for the months of January and April 2016 and September and December 2015. ◦ April 12, 2016 – 11:30am – 12:30pm – Home visit. ◦ April 28, 2016 – 3:50pm – 4:30pm – Home visit ◦ January 11, 2016 – 4:00pm – 5:00pm – Home visit. ◦ January 27, 2016 – 1:00pm – 2:00pm – Home visit. ◦ December 21, 2015 – 2:45pm – 4:00pm – Home visit. ◦ December 30, 2015 – 3:30pm – 4:30pm – Home visit.		

	◦ September 28, 2015 – 3:30pm – 4:15pm – Home visit. ◦ September 28, 2015 – 3:30pm – 4:15pm – Home visit.		

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; 6/15/2015 **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.	Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 17 of 30 individuals. Review of the Agency individual case files revealed no evidence of quarterly/bi-annual reports for the following: • **Supported Living Quarterly Reports:** ◦ Individual #11 – None found for May 2016 - July 2016. *(Term of ISP 5/01/2016 – 4/30/2017*). ◦ Individual #16 – None found for July 2015 – March 2016. *(Term of ISP 7/13/2015 – 7/30/2016) (ISP meeting held 4/01/2016*). • **Supported Living Semi-Annual Reports:** ◦ Individual #5 – None found for May 2015 – February 2016. *(Term of ISP 5/27/2015 – 5/26/2016) (ISP meeting held 2/26/2016*). ◦ Individual #7 – None found for May 2015 – August 2015. *(Term of ISP 11/17/2014 – 11/16/2015) (ISP meeting held 9/02/2015*). ◦ Individual #14 – None found for April 2015 – December 2015. *(Term of ISP 4/01/2015 – 3/31/2016) (ISP meeting held 12/11/2015)*. ◦ Individual #21 – None found for November 2015 – April 2016. *(Term of ISP 11/02/2015 – 11/01/2016)*.	**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?)*: → **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?)*: →	

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: 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	◦ Individual #24 – None found for February 2016 – August 2016. *(Term of ISP 2/13/2016 – 2/12/2017)*. ◦ Individual #27 – None found for June 2015 – January 2016. *(Term of ISP 6/5/2015 – 6/4/2016) (ISP meeting held 2/2/2016*). • **Family Living Semi - Annual Reports:** ◦ Individual #4 – None found for February 2015 – October 2015. *(Term of ISP 2/22/2015 – 2/21/2016) (ISP meeting held 10/26/2015)*. ◦ Individual #10 – None found for May 2015 – August 2015. *(Term of ISP 11/25/2014 – 11/24/2015) (ISP meeting held 9/9/2015*). • **Customized Community Supports Semi-Annual Reports:** ◦ Individual #4 – None found for February 2015 – October 2015. *(Term of ISP 2/22/2015 – 2/21/2016*) *(ISP meeting held 10/26/2015).* ◦ Individual #5 – None found for May 2015 – February 2016*. (Term of ISP 5/27/2015 – 5/26/2016) (ISP meeting held 2/26/2016).* ◦ Individual #6 – None found for April 2015 – December 2015. *(Term of ISP 4/3/2015 – 4/2/2016) (ISP meeting held 12/29/2015).* ◦ Individual #7 – None found for May 2015 – August 2015. *(Term of ISP 11/17/2014 – 11/15/2015) (ISP meeting held 9/2/2015)*. ◦ Individual #10 – None found for May 2015 – August 2015 and November 2015 – May 2016 April 2016. *(Term of ISP 11/25/2014*		

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. 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	*– 11/24/2015 & 11/25/2015 – 11/24/2016) (ISP meeting held 9/09/2015).* ◦ Individual #14 – None found for April 2015 – December 2015. *(Term of ISP 4/1/2015 – 3/31/2016) (ISP meeting held 12/11/2015)*. ◦ Individual #15 – None found for May 2015 – November 2015. *(Term of ISP 5/19/2015 – 5/18/2016*). ◦ Individual #24 – None found for February 2016 – August 2016. *(Term of ISP 2/13/2016 – 2/12/2017*). ◦ Individual #26 – None found for September 2015 – March 2016. *(Term of ISP 9/11/2015 – 9/10/2016*). ◦ Individual #27 – None found for June 2015 – January 2016. *(Term of ISP 6/5/2015 – 6/4/2016) (ISP meeting held 2/2/2016).* • **Community Integrated Employment Semi-Annual Reports:** ◦ Individual #3 – None found for August 2015 – April 2016. *(Term of ISP 8/3/2015 – 8/2/2016) (ISP meeting held 4/15/2016).* ◦ Individual #14 – None found for April 2015 – November 2015. *(Term of ISP 4/01/2015 – 3/31/2016) (ISP meeting held 12/11/2015)*. ◦ Individual #15 – None found for May 2015 – January 2016. *(Term of ISP 5/19/2015 – 5/18/2016) (ISP meeting held 1/21/2016).*		

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.	◦ Individual #24 – None found for February 2016 – August 2016. *(Term of ISP 2/13/2016 – 2/12/2017*). • **Community Inclusion - Adult Habilitation Quarterly Reports:** ◦ Individual #16 – None found for July 2015 – April 2016. *(Term of ISP 7/13/2015 – 7/30/2016*). ◦ Individual #30 – None found for September 2015 – February 2016. *(Term of ISP 9/01/2015 – 8/31/2016*). • **Customized In-Home Supports Semi-Annual Reports:** ◦ Individual #15 – None found for May 2015 – November 2015. *(Term of ISP 5/19/2015 – 5/18/2016).* • **Behavior Support Consultation Semi - Annual Progress Reports:** ◦ Individual #4 – None found for February 2015 – August 2015. *(Term of ISP 2/22/2015 – 2/21/2016*). ◦ Individual #14 – None found for April 2015 – September 2015. *(Term of ISP 4/1/2015 – 3/31/2016*). ◦ Individual #15 – None found for May 2015 – November 2015. *(Term of ISP 5/19/2015 – 5/18/2016*). ◦ Individual #21 – None found for November 2015 – April 2016. *(Term of ISP 11/2/2015 – 11/1/2016*).		

(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	◦ Individual #27 – None found for June 2015 – November 2015. *(Term of ISP 6/5/2015 – 6/4/2016*). ◦ Individual #29 – None found for February 2016 – August 2016. *(Term of ISP 2/20/2016 – 2/19/2017*). • **Speech Therapy Semi - Annual Progress Reports:** ◦ Individual #29 – None found for February 2016 – August 2016. *(Term of ISP 2/20/2016 – 2/19/2017*). ◦ Individual #30 – None found for September 2015 – February 2016. *(Term of ISP 9/1/2015 – 8/31/2016*). • **Occupational Therapy Semi - Annual Progress Reports:** ◦ Individual #21 – None found for November 2015 – April 2016. *(Term of ISP 11/2/2015 – 11/1/2016*). ◦ Individual #29 – None found for February 2015 – July 2015 and February 2016 – July 2016. *(Term of ISP 2/20/2015 – 2/19/2016 and 2/20/2016 – 2/19/2017*). • **Physical Semi - Annual Progress Reports:** ◦ Individual #21 – None found for November 2015 – April 2016. *(Term of ISP 11/2/2015 – 11/1/2016*). ◦ Individual #30 – None found for September 2015 – February 2016. *(Term of ISP 9/1/2015 – 8/31/2016*).		

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	• **Nursing Semi - Annual Reports:** ◦ Individual #5 – None found for May 2015 – November 2015. *(Term of ISP 5/27/2015 – 5/26/2016*). ◦ Individual #6 – None found for April 2015 – December 2015. *(Term of ISP 4/3/2015 – 4/2/2016) (ISP meeting held 12/29/2015).* ◦ Individual #7 – None found for May 2015 – August 2015. *(Term of ISP 11/17/2014 – 11/15/2015) (ISP meeting held 9/02/2015).* ◦ Individual #10 – None found for May 2015 – August 2015 and November 2015 – May 2016. *(Term of ISP 11/25/2014 – 11/24/2015 & 11/25/2015 – 11/24/2016) (ISP meeting held 9/09/2015).* ◦ Individual #14 – None found for April 2015 – November 2015. *(Term of ISP 4/1/2015 – 3/31/2016) (ISP meeting held 12/11/2015).* ◦ Individual #19 – None found for April 2015 – August 2015 and October 2015 – March 2016. *(Term of ISP 10/1/2014 – 9/30/2015 & 10/1/2015 – 9/30/2016) (ISP meeting held 8/28/2015).* ◦ Individual #21 – None found for November 2015 – April 2016. *(Term of ISP 11/2/2015 – 11/1/2016*). ◦ Individual #27 – None found for June 2015 – January 2016. *(Term of ISP 6/5/2015 – 6/4/2016) (ISP meeting held 2/02/2016)*. ◦ Individual #29 – None found for August 2015 – November 2015 and February 2016		

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.	– August 2016. *(Terms of ISP 2/20/2015 – 2/19/2016 & 2/20/2016 – 2/19/2017) (ISP meeting held 11/05/2015)*.		

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; 6/15/2015 **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 interview the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 5 of 30 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: **Wen Case Managers were asked if the Individual's most current ISP was distributed to the IDT within the required time frame, the following was reported**: • #200 stated, "Probably not." (Individual #3) • #200 stated, "No, I'm still working on it." (Individual #10) • #200 stated, "Probably not." (Individual #27) • #209 stated, "No." (individual #9) • #209 stated, "No it was not." (Individual #30)	**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?)*: → **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?)*: →	

(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 be 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: Level of Care – *Initial and annual Level of Care (LOC) evaluations are completed within timeframes specified by the State.*			
Tag # 4C04 Assessment Activities	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 4 (CMgt) I. Case Management Services: 1. Scope of Services: S.** Maintain a complete record for the individual's DDW services, as specified in DDSD Consumer Records Requirements Policy; **2. Service Requirements: B. Assessment:** The Case Manager is responsible to ensure that an initial evaluation for LOC is complete for all participants, and that all participants who are reevaluated for LOC at least annually. The assessment tasks of the case manager include, but are not limited to: 1. Completes, compiles, and/or obtains the elements of the Long Term Care Assessment Abstract (Long Term Care Assessment Abstract) packet to include: a. Long Term Care Assessment Abstract form (MAD 378); b. Comprehensive Individual Assessment (CIA); c. Current physical exam and medical/clinical history; d. For children: a norm-referenced assessment will be completed; and e. A copy of the Allocation Letter (initial submission only).	Based on record review, the Agency did not complete and compile the elements of the Long Term Care Assessment Abstract (LTCAA) packet for 6 of 30 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Annual Physical (#4, 6, 14, 29) • Level of Care (#13, 14, 30)	**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?)***: →** **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?)***: →**	

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; b. The Case Manager shall respond to TPA Contractor within specified timelines when the Long Term Care Assessment Abstract packet is returned for corrections or additional information; c. The Case Manager will submit the Long Term Care Assessment Abstract packet to the TPA Contractor, for review and approval. For all annual redeterminations, submission shall occur between forty-five (45) calendar days and thirty (30) calendar days prior to the LOC expiration date; and d. The Case Manager will facilitate re-admission to the DDW for individuals hospitalized more than three (3) calendar days (upon the third midnight). This includes ensuring that hospital discharge planners submit a re-admit LOC to the TPA Contractor and obtain and distribute a copy of the approved document for the client's file.			

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS** **B**. **Case Management Assessment Activities:** Assessment activities shall include but are not limited to the following requirements: (1) Complete and compile the elements of the Long Term Care Assessment Abstract (LTCAA) packet to include: (a) LTCAA form (MAD 378); (b) Comprehensive Individual Assessment (CIA); (c) Current physical exam and medical/clinical history; (d) Norm-referenced adaptive behavioral assessment; and (e) A copy of the Allocation Letter (initial submission only). (2) Prior to service delivery, obtain a copy of the Medical Assistant Worker (MAW) letter to verify that the county Income Support Division (ISD) office of the Human Services Department (HSD) has completed a determination that the individual meets financial and medical eligibility to participate in the DD Waiver program. (3) Provide a copy of the MAW letter to service providers listed on the ISP budget (MAD 046).			

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A28.1 **Incident Mgt. System - Personnel Training**	***Condition of Participation Level Deficiency***		
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the	After an analysis of the evidence it has been determined that there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation verifying completion of Incident Management Training for 11 of 11 Agency Personnel. • Incident Management Training (Abuse, Neglect & Exploitation) (#200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210)	**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?)***: →** **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?)***: →**	

community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer. **C. Incident management system training curriculum requirements:** **(1)** The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, or exploitation; **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths; **(d)** specific instructions on how to respond to abuse, neglect, or exploitation; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. **(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule. **(3)** All new employees and volunteers shall receive training prior to providing services to consumers. **D. Training documentation:** All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six			

months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.			

Tag # 4C17 Case Manager Qualifications - Required Training	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 4 (CMgt) 3. Agency Requirements: C. Programmatic Requirements: H. Training:** 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… 2. All Case Managers are required to understand and to adhere to the Case Manager Code of Ethics. **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:** A. Individuals shall receive services from competent and qualified case managers. 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.	Based on record review, the Agency did not ensure that Training requirements were met for 1 of 11 Case Managers. Review of Case Manager training records found no evidence of the following required DOH/DDSD trainings being completed: • Pre-Service Part Two (#204)	**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?)*: → **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?)*: →	

C. Case management staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. D. In addition to the applicable requirements described in policy statements B – C (above), case managers and case management supervisors shall complete DDSD-approved core curriculum training... E. Substitutes shall comply with the training requirements of the staff for whom they are substituting. F. To complete a core curriculum-training course, trainees shall achieve 100% competency rating during the competency verification process.			

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
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.*			
Tag # 1A03 CQI System	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **(Case Mgt) Chapter 4. 3. Agency Requirements M. Quality Assurance/Quality Improvement (QA/QI) Activities:** 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: 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;	Based on record review and interview, the Agency did not develop and implement a Continuous Quality Management System. Review of the Agency's Continuous Quality Improvement Plan provided during the on-site survey did not contain the components required by Standards. The Agency's CQI Plan did not contain the following components: i. Compliance with Employee Abuse Registry requirements; When asked if the Agency had an Internal Quality Assurance & improvement Plan to address Compliance with Employee Abuse Registry requirements, the following was reported: Co-Director's #209 and #210 reviewed the Agency's Quality Assurance/Quality Improvement Plan, however, they were unable to provide evidence that information on the Employee Abuse Registry requirement was included in their QA/QI Plan.	**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?)***: →** **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?)***: →**	

b. **Implementing a QA/QI Committee:** The QA/QI committee shall convene on at least a quarterly 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; c. **The QA review should address at least the following:** 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. 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 must be submitted to the relevant DDSD Regional Office. The report will summarize: 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.			

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 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: **(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.			

Tag # 1A29 Complaints / Grievances - Acknowledgement	Standard Level Deficiency		
NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure	Based on record review, the Agency did not provide documentation indicating the complaint procedure had been made available to individuals or their legal guardians for 1 of 30 individuals. • Grievance/Complaint Procedure Acknowledgement (#29)	**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?)*: → **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?)*: →	

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; 6/15/2015

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 1 of 30 individuals. *Progress notes and billing records supported billing activities for the months of May, June and July 2016.*

Date: October 31, 2016

To: Carrie Lyon, Co-Director
Provider: Sun Country Case Management
Address: 133 Wyatt Drive # 4
State/Zip: Las Cruces, New Mexico 88005

E-mail Address: carriel@sccmsllc.com

CC: Natasha Rackoff Ruiz, Co-Director
Address: 133 Wyatt Drive # 4
State/Zip: Las Cruces, New Mexico 88005

E-Mail Address: natashar@sccmsllc.com

Region: Southwest
Survey Date: September 2 – 9, 2016
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2007 & 2012:** Case Management

Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Lyon,

Your request for a Reconsideration of Findings was received on October 19, 2016. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 4C02
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated.

Based on the QMB Document Request Form, a Primary Freedom of Choice for Individual #5 was requested from and signed by Geysi Zuniga on 09/06/2016. The agency was given the opportunity to reconcile documentation and a final copy of the QMB Document Request Form, still listing this item as not provided or justified, was given to the agency and signed by Carrie Lyon on 09/09/2016 indicating acknowledgement of the finding. Although the documentation provided during the IRF will be acceptable in lieu of a Primary Freedom of Choice, no documentation and/or justification was provided to surveyors while on-site to refute the finding.

Regarding Tag # 1A28.1
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation provided and reviewed, the finding for Case Manager #204 will be removed. The findings for all other Case Managers cited will remain as Annual Incident Management Training has been a requirement in all versions of NMAC and should have been completed regardless.

Regarding Tag # 4C17
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation reviewed and discussion with Kristin Hansen of the DDSD Training Unit, Pre-Service Part II should be completed within 90 days of employment. Case Manager #204 was hired on 4/25/2016 and should have had this training completed prior to the QMB on-site survey of 9/02-09/2016. Also Sun Country's Agency Policy on Pre-Service should be revised to state Pre-Service Part II completed within 90 days of employment, not 180 days.

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

Thank you.
Respectfully,

Crystal Lopez-Beck

Crystal Lopez-Beck
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

Q.17.1.DDW.D0325.3.RTN.12.16.305

Date: December 21, 2016

To: Carrie Lyon, Co-Director
Provider: Sun Country Case Management
Address: 133 Wyatt Drive # 4
State/Zip: Las Cruces, New Mexico 88005

E-mail Address: carriel@sccmsllc.com

CC: Natasha Rackoff Ruiz, Co-Director
Address: 133 Wyatt Drive # 4
State/Zip: Las Cruces, New Mexico 88005

E-Mail Address: natashar@sccmsllc.com

Region: Southwest
Survey Date: September 2 – 9, 2016
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2007 & 2012:** Case Management

Survey Type: Routine

Dear Ms. Lyon;

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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