**Scoring Modified as result of Pilot 1 9/25/2018**

Date: July 11, 2018

To: Gabriela Ramos, Executive Director
Provider: Carino Case Management Inc
Address: 2701 San Pedro Dr NE #10
State/Zip: Albuquerque, New Mexico 87110

E-mail Address: gbramos@comcast.net

Region: Metro
Survey Date: June 22 - 29, 2018

Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: ***2007, 2012 & 2018 :*** Case Management

Survey Type: Routine

Team Leader: Wolf Krusemark, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Kandis Gomez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Tony Fragua, BFA, Healthcare Program Manager, Division of Health Improvement/Quality Management Bureau; Deb Russell, BS Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Gabriela Ramos:

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

**Determination of Compliance:**

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

***Compliance:*** This determination is based on your agency's compliance with Condition of Participation level and Standard level requirements. Deficiencies found only affect a small percentage of the Individuals on the survey sample *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

The following tags are identified as Standard Level Deficiencies:

- Tag # 1A08 Administrative Case File
- Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components
- Tag # 4C10 Apprv. Budget Worksheet Waiver Review Form / MAD 046
- Tag # 4C12 Monitoring & Evaluation of Services
- Tag # 4C15.1 Service Monitoring: Annual / Semi-Annual Reports & Provider Semi – Annual / Quarterly Report
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)

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

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

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

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

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

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

1. **Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator 1170 North Solano Suite D Las Cruces, New Mexico 88001**

2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

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

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

**Billing Deficiencies:**
If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a "Void/Adjust" claim or remit the identified overpayment via a check within 30 calendar days of the

date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

*Attention: Lisa Medina-Lujan*
HSD/OIG
Program Integrity Unit
2025 S. Pacheco Street
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*
*1474 Rodeo Road*
*Santa Fe, New Mexico 87505*

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

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

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

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

Please call the Plan of Correction Coordinator Amanda Castaneda at 575-373-5716 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Wolf Krusemark, BFA

Wolf Krusemark, BFA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

## Survey Process Employed:

| | |
|---|---|
| Administrative Review Start Date: | June 22, 2018 |
| Contact: | **Carino Case Management Inc**<br>Gabriela Ramos, Executive Director<br><br>**DOH/DHI/QMB**<br>Wolf Krusemark, BFA, Team Lead/Healthcare Surveyor |
| On-site Entrance Conference Date: | June 25, 2018 |
| Present: | **Carino Case Management, Inc**<br>Gabriela Ramos, Executive Director<br>Margaret Terry, Case Manager<br>Linda Boddy, Case Manager<br><br>**DOH/DHI/QMB**<br>Wolf Krusemark, BFA, Team Lead/Healthcare Surveyor<br>Kandis Gomez, AA, Healthcare Surveyor<br>Tony Fragua, BFA, Healthcare Program Manager<br>Deb Russel, BS, Healthcare Surveyor<br><br>**JCA Consultant**<br>Rosanna Soloperto |
| Exit Conference Date: | June 29, 2018 |
| Present: | **Carino Case Management, Inc**<br>Gabriela Ramos, Executive Director<br>Jo Brewer, Case Manager<br><br>**DOH/DHI/QMB**<br>Wolf Krusemark, BFA, Team Lead/Healthcare Surveyor<br>Kandis Gomez, AA, Healthcare Surveyor<br>Tony Fragua, BFA, Healthcare Program Manager<br>Deb Russel, BS, Healthcare Surveyor<br><br>**DDSD - Metro Regional Office**<br>Jason Cornwell, Assistant Director<br>Michelle Flores, Case Manager |
| Administrative Locations Visited: | 1 |
| Total Sample Size: | 23<br><br>3 - *Jackson* Class Members<br>20 - Non-*Jackson* Class Members |
| Persons Served Records Reviewed | 23 |
| Total Number of *Secondary Freedom of Choices* Reviewed: | 107 |
| Case Management Personnel Records Reviewed | 8 |
| Case Manager Personnel Interviewed | 8 |

Administrative Interviews 1

Administrative Processes and Records 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
    - Medication Administration Records
    - Medical Emergency Response Plans
    - Therapy Evaluations and Plans
    - Healthcare Documentation Regarding Appointments and Required Follow-Up
    - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Quality Assurance / Improvement Plan

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

**Attachment A**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***Completion Dates***

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

***Initial Submission of the Plan of Correction Requirements***

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

***POC Document Submission Requirements***

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

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

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

**Attachment B**

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

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

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

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

**Conditions of Participation (CoPs)**

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

**Service Domains and CoPs for <u>Case Management</u> are as follows:**

**<u>Service Domain: Plan of Care ISP Development & Monitoring -</u>** *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.*

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

1. **1A08.3 –** Administrative Case File - Individual Service Plan (ISP) / ISP Components
2. **4C07 –** Individual Service Planning (Visions, measurable outcome, action steps)
3. **4C07.1 –** Individual Service Planning – Paid Services
4. **4C10 –** Apprv. Budget Worksheet Waiver Review Form / MAD 046
5. **4C12 –** Monitoring & Evaluation of Services
6. **4C16 –** Requirements for Reports & Distribution of ISP (Provider Agencies, Individual and/or Guardian)

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

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

**4C04 –** Assessment Activities

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

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

- **1A22/4C02 –** Case Manager: Individual Specific Competencies
- **1A22.1 / 4C02.1 –** Case Manager Competencies: Knowledge of Service

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

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

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

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

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

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

- **1A05 –** General Requirements

**Attachment C**

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

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

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

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.

**Attachment D**

## QMB Determinations of Compliance

**Compliance:**

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

**Partial-Compliance with Standard Level Tags:**

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

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.

2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

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

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

**Non-Compliance:**

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

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

2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

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

**Agency:** **Carino Case Management, Inc. – Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2007, 2012, 2018:*** Case Management
Survey Type: Routine
**Survey Date:** **June 22-29, 2018**

| 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 Administrative Case File** | **Standard Level Deficiency** | | |
| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018<br>**Chapter 8 Case Management: 8.2.8**<br>***Maintaining a Complete Client Record:***<br>The CM is required to maintain documentation for each person supported according to the following requirements:<br>3. The case file must contain the documents identified in Appendix A Client File Matrix.<br><br>**Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.<br>DD Waiver Provider Agencies are required to adhere to the following:<br>1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of | Based on record review, the Agency did not maintain a complete client record at the administrative office for 1 of 23 individuals.<br><br>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:<br><br>**Individual Data Form:**<br>• Did not contain Occupational Therapist Information (#12)<br><br>• Did not contain Physical Therapist Information (#12) | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| the person during the provision of the service.<br>2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable.<br>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.<br>4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.<br>5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.<br>6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.<br>7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.<br><br>***20.5.1 Individual Data Form (IDF):***<br>The Individual Data Form provides an overview of demographic information as well as other key personal, programmatic, insurance, and | | | |

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| health related information. It lists medical information; assistive technology or adaptive equipment; diagnoses; allergies; information about whether a guardian or advance directives are in place; information about behavioral and health related needs; contacts of Provider Agencies and team members and other critical information. The IDF automatically loads information into other fields and forms and must be complete and kept current. This form is initiated by the CM. It must be opened and continuously updated by Living Supports, CCS- Group, ANS, CIHS and case management when applicable to the person in order for accurate data to auto populate other documents like the Health Passport and Physician Consultation Form. Although the Primary Provider Agency is ultimately responsible for keeping this form current, each provider collaborates and communicates critical information to update this form.<br><br>***Chapter 3 Safeguards 3.1.2 Team Justification Process:*** DD Waiver participants may receive evaluations or reviews conducted by a variety of professionals or clinicians. These evaluations or reviews typically include recommendations or suggestions for the person/guardian or the team to consider. The team justification process includes:<br>1. Discussion and decisions about non-health related recommendations are documented on the Team Justification form.<br>2. The Team Justification form documents that the person/guardian or team has considered the recommendations and has decided:<br>a. to implement the recommendation;<br>b. to create an action plan and revise the | | | |

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| ISP, if necessary; or<br>c. not to implement the recommendation currently.<br>3. All DD Waiver Provider Agencies participate in information gathering, IDT meeting attendance, and accessing supplemental resources if needed and desired.<br>4. The CM ensures that the Team Justification Process is followed and complete.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015<br>**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; | | | |

| Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components | Standard Level Deficiency *(Modified as result of Pilot 1)* | | |
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| **NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY.**<br><br>**NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS.**<br><br>**NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.**<br><br>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018<br>**Chapter 8 Case Management: 8.2.8**<br>***Maintaining a Complete Client Record:***<br>The CM is required to maintain documentation for each person supported according to the following requirements:<br>3. The case file must contain the documents identified in Appendix A Client File Matrix.<br><br>**Chapter 6 Individual Service Plan:** The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP.<br><br>***6.5.2 ISP Revisions:*** The ISP is a dynamic document that changes with the person's desires, circumstances, and need. IDT members must collaborate and request an IDT meeting from the CM when a need to modify the ISP arises. The CM convenes the IDT within ten days of receipt of any reasonable request to convene the team, either in person or through teleconference. | Based on record review, the Agency did not maintain a complete client record at the administrative office for 1 of 23 individuals.<br><br>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:<br><br>• Not Fully Constituted IDT *(No evidence of Customized Community Supports Staff involvement)* (#7) | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| **6.6 DDSD ISP Template:** The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e. an acknowledgement of receipt of specific information) and other elements depending on the age of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use in order to better demonstrate required elements of the PCP process and ISP development.<br>The ISP is completed by the CM with the IDT input and must be completed according to the following requirements:<br>1. DD Waiver Provider Agencies should not recommend service type, frequency, and amount (except for required case management services) on an individual budget prior to the Vision Statement and Desired Outcomes being developed.<br>2. The person does not require IDT agreement/approval regarding his/her dreams, aspirations, and desired long-term outcomes.<br>3. When there is disagreement, the IDT is required to plan and resolve conflicts in a manner that promotes health, safety, and quality of life through consensus. Consensus means a state of general agreement that allows members to support the proposal, at least on a trial basis.<br>4. A signature page and/or documentation of participation by phone must be completed.<br>5. The CM must review a current Addendum A and DHI ANE letter with the person and Court appointed guardian or parents of a minor, if | | | |

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| applicable.<br><br>**6.7 Completion and Distribution of the ISP:** The CM is required to assure all elements of the ISP and companion documents are completed and distributed to the IDT...<br><br>**Chapter 20: Provider Documentation and Client Records**<br>**20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015<br>**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;<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**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 | | | |

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| requirements and personnel qualifications may be applicable for specific service standards.<br><br>**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:<br>(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;<br>(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);<br>(3) Progress notes and other service delivery documentation;<br>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;<br>(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;<br>(6) When applicable, transition plans completed for individuals at the time of discharge from | | | |

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| Fort Stanton Hospital or Los Lunas Hospital and Training School; and<br>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.<br>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:<br>(a) Complete file for the past 12 months;<br>(b) ISP and quarterly reports from the current and prior ISP year;<br>(c) Intake information from original admission to services; and<br>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital. | | | |

| Tag # 4C10 Apprv. Budget Worksheet Waiver Review Form / MAD 046 | Standard Level Deficiency *(Modified as result of Pilot 1)* | | |
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| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 7: Available Services and Individual Budget Development:** DD Waiver services are designed to support people to live the life they prefer in the community of their choice, and to gain increased community involvement and independence according to their personal and cultural preferences. Services available through the DD Waiver are required to comply with New Mexico's DD Waiver approved by CMS and with any subsequent amendments approved by CMS during the five-year waiver renewal period. The individual budget development process must first include PCP, then development of an ISP, and finally identification of service types and amounts to meet the needs and preferences of individuals receiving services.<br><br>***7.3.1 Jackson Class Members (JCM):*** Individuals included in the class established pursuant to Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, 757 F. Supp. 1243 (DNM 1990) may receive service types and budget amounts consistent with those services approved in their ISP and in accordance with the Orders of the Consent Decree. JCMs budgets are not submitted to the Outside Reviewer(OR) for clinical justification according to the process described below. DDSD provides instruction to CM's on JCM budget submission and system entry.<br><br>***7.3.2 Clinical Justification and the Outside Review Process:*** DDSD contracts with an independent third party to conduct a clinical outside review (OR) of services and service amounts requested on an adult budget. DD | Based on record review, the Case Manager did not submit the Budget Worksheet Waiver Review Form or MAD 046 Waiver Review Form to the TPA Contractor for review as appropriate, and/or for data entry at least thirty (30) calendar days prior to expiration of the ISP for 1 of 23 Individuals.<br><br>**The following item was found:**<br><br>**Budget Worksheet Waiver Review Form or MAD 046 Submitted Less Than 60-Days Prior to ISP Expiration (NON- JCM):**<br><br>• Individual #7 | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| Waiver services have a set of clinical criteria applied by the OR to determine clinical justification. Clinical Criteria was first implemented in October 2015 and undergoes periodic updates when clarification is needed for the field and the reviewers or when policy or program decisions affect the criteria.<br><br>***7.3.3 Adult Budget Submission Process:*** The CM is responsible for timely submission of the ISP, budget worksheet (BWS), and supporting documentation to the OR. To avoid any disruption or delays in approval of clinically justified services, all DD Waiver Provider Agencies on a BWS are responsible for working with the CM to assure accuracy and completeness of the submission.<br><br>**Chapter 8 Case Management: 8.2.8**<br>***Maintaining a Complete Client Record:***<br>The CM is required to maintain documentation for each person supported according to the following requirements:<br>3. The case file must contain the documents identified in Appendix A Client File Matrix.<br><br>**Chapter 20: Provider Documentation and Client Records**<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015<br>**CHAPTER 4 (CMgt) 2. Service Requirements: C. Service Planning:**<br>vi. The Case Manager ensures completion of the post IDT activities, including:<br><br>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 | | | |

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| Contractor only after documented verification of financial and medical eligibility has been received;<br><br>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;<br><br>C. Prior to the delivery of any service, the TPA Contractor must approve the following:<br>a. The Budget Worksheet Waiver Review Form (clinical necessity) or MAD 046;<br><br>b. All Initial and Annual ISPs; and<br><br>c. Revisions to the ISP, involving changes to the budget.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS**<br>**H. Case Management Approval of the MAD 046 Waiver Review Form and Budget**<br>(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.<br>(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 | | | |

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| 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.<br>(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.<br>(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 | | |
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| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018<br>**Chapter 8 Case Management: 8.2.8**<br>***Maintaining a Complete Client Record:***<br>The CM is required to maintain documentation for each person supported according to the following requirements:<br>3. The case file must contain the documents identified in Appendix A Client File Matrix.<br><br>***8.2.7 Monitoring and Evaluating Service Delivery:*** The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health and safety of the person. Monitoring and evaluation activities include the following requirements:<br>1. The CM is required to meet face-to-face with adult DD Waiver participants at least 12 times annually (one time per month) to bill for a monthly unit.<br>2. JCMs require two face-to-face contacts per month to bill the monthly unit, one of which must occur at a location in which the person spends the majority of the day (i.e., place of employment, habilitation program), and the other contact must occur at the person's residence.<br>3. Parents of children on the DD Waiver must receive a minimum of four visits per year, as established in the ISP. The parent is responsible for monitoring and evaluating services provided in the months case management services are not received.<br>4. No more than one IDT Meeting per quarter may count as a face-to-face contact for adults | 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 1 of 23 individuals.<br><br>**Review of the Agency individual case files revealed face-to-face visits were not being completed as required by standard (#2, #5 a, b, c) for the following individuals:**<br><br>**Individual #7** (Non-Jackson)<br>No site visit was noted between 3/2018 - 5/2018.<br>• 3/19/2018 – 2:15-3:15 – Home<br><br>• 4/23/2018 – 2:15-3:15 – Home<br><br>• 5/14/2018 – 2:15-3:15 – Home<br><br>No site visit was noted between 9/2017 - 11/2017.<br>• 9/11/2017 – 2:15-3:15 – Home<br><br>• 10/23/2017 – 2:15-3:15 – Home<br><br>• 11/13/2017 – 2:00-3:00 – Home | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| (including JCMs) living in the community.<br>5. For non-JCMs, face-to-face visits must occur as follows:<br>a. At least one face-to-face visit per quarter shall occur at the person's home for people who receive a Living Supports or CIHS.<br>b. At least one face-to-face visit per quarter shall occur at the day program for people who receive CCS and or CIE in an agency operated facility.<br>c. It is appropriate to conduct face-to-face visits with the person either during times when the person is receiving a service or during times when the person is not receiving a service.<br>d. The CM considers preferences of the person when scheduling face-to face-visits in advance.<br>e. Face-to-face visits may be unannounced depending on the purpose of the monitoring.<br>6. The CM must monitor at least quarterly:<br>a. that applicable MERPs and/or BCIPs are in place in the residence and at the day services location(s) for those who have chronic medical condition(s) with potential for life threatening complications, or for individuals with behavioral challenge(s) that pose a potential for harm to themselves or others; and<br>b. that all applicable current HCPs (including applicable CARMP), PBSP or other applicable behavioral plans (such as PPMP or RMP), and WDSIs are in place in the applicable service sites.<br>7. When risk of significant harm is identified, the CM follows. the standards outlined in Chapter 18: Incident Management System. | | | |

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| 8. The CM must report all suspected ANE as required by New Mexico Statutes and complete all follow up activities as detailed in Chapter 18: Incident Management System.<br>9. If concerns regarding the health or safety of the person are documented during monitoring or assessment activities, the CM immediately notifies appropriate supervisory personnel within the DD Waiver Provider Agency and documents the concern. In situations where the concern is not urgent, the DD Waiver Provider Agency is allowed up to 15 business days to remediate or develop an acceptable plan of remediation.<br>10. If the CMs reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed upon period of time, the CM shall use the RORA process detailed in Chapter 19: Provider Reporting Requirements.<br>11. The CM conducts an online review in the Therap system to ensure that the e-CHAT and *Health Passport* are current: quarterly and after each hospitalization or major health event.<br>14. The CM will ensure Living Supports, CIHS, CCS, and CIE are delivered in accordance with CMS Setting Requirements described in Chapter 2.1 CMS Final Rule: Home and Community-Based Services (HCBS) Settings Requirements. If additional support is needed, the CM notifies the DDSD Regional Office through the RORA process.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015<br>**CHAPTER 4 (CMgt) 2. Service Requirements: D. Monitoring And Evaluation of Service Delivery:** | | | |

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| 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.<br><br>2. Monitoring and evaluation activities shall include, but not be limited to:<br>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.<br>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.<br>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.<br>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.<br>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 | | | |

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| services. The third quarterly visit is at the discretion of the Case Manager.<br><br>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.<br><br>4. Visits may be scheduled in advance or be unannounced, depending on the purpose of the monitoring of services.<br><br>5. The Case Manager must ensure at least quarterly that:<br><br>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<br>b. All applicable current Healthcare plans, Comprehensive Aspiration Risk Management Plan (CARMP), Positive Behavior Support Plan (PBSP or other applicable behavioral support plans (such as BCIP, PPMP, or RMP), and written Therapy Support Plans are in place in the residence and day service sites for individuals who receive Living Supports and/or Customized Community Supports (day services), and who have such plans.<br><br>6. The Case Managers will report all suspected abuse, neglect or exploitation as required by New Mexico Statutes; | | | |

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| 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.<br><br>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:<br><br>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).<br>b. The Case Management Provider Agency will keep a copy of the RORI in the individual's record.<br><br>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.<br><br>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 | | | |

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| 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.<br><br>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.<br><br>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.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS: J. Case Manager Monitoring and Evaluation of Service Delivery** | | | |

| Tag # 4C15.1 Service Monitoring: Annual / Semi-Annual Reports & Provider Semi – Annual / Quarterly Report | Standard Level Deficiency | | |
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| **7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:**<br>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.<br><br>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018<br>**Chapter 8 Case Management: 8.2.8 *Maintaining a Complete Client Record:***<br>The CM is required to maintain documentation for each person supported according to the following requirements:<br>3. The case file must contain the documents identified in Appendix A Client File Matrix.<br><br>**8.2.7 *Monitoring and Evaluating Service Delivery:*** The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person | Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 8 of 23 individuals.<br><br>Review of the Agency individual case files revealed no evidence of quarterly/bi-annual reports for the following:<br><br>**Supported Living Semi-Annual Reports:**<br>• Individual #2 – Report not completed 14 days prior to annual ISP meeting. (*Semi-Annual Report 9/22/2017 – 6/20/2018;* Date Completed: *6/20/2018; ISP meeting held on 6/19/2018) (Due Diligence. No Plan of Correction Required).*<br><br>• Individual #28 – Report not completed 14 days prior to annual ISP meeting. (*Semi-Annual Report 3/1/2017 – 11/30/2017;* Date Completed: *12/13/2017; ISP meeting held on 12/4/2017).*<br><br>**Family Living Semi-Annual Reports:**<br>• Individual #11 – Report not completed 14 days prior to annual ISP meeting. (*Semi-Annual Report 5/12/2017- 7/26/2017;* Date Completed: *10/2017; ISP meeting held on 8/9/2017).*<br><br>**Customized Community Supports Semi-Annual Reports:**<br>• Individual #11 – Report not completed 14 days prior to annual ISP meeting. (*Semi-* | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| as specified in the ISP. The CM is also responsible for monitoring the health and safety of the person…<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015<br>**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.<br>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:<br>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:<br><br>**D. Monitoring And Evaluation of Service Delivery:**<br>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. | *Annual Report 12/12/2016 – 8/9/2017;* Date Completed: 8/9/2017*; ISP meeting held on 8/9/2017).*<br><br>• Individual #28 – Report not completed 14 days prior to annual ISP meeting. (*Semi-Annual Report 3/1/2017 – 11/20/2017;* Date Completed: 12/1/2017*; ISP meeting held on 12/4/2017)*<br><br>**Community Integrated Employment Semi-Annual Reports:**<br>• Individual #11 – Report not completed 14 days prior to annual ISP meeting. (*Semi-Annual Report 11/12/2017 – 5/12//2018;* Date Completed: *8/9/2017; ISP meeting held on 8/9/2017).*<br><br>**Behavior Support Consultation Semi - Annual Progress Reports:**<br>• Individual #30 – None found for October 2017 Report covered *11/2017 – 4/2018*. *(Term of ISP 9/2017 – 9/2018. ISP meeting held 6/20/2017). (Per regulations reports must coincide with ISP term).*<br><br>**Occupational Therapy Semi - Annual Progress Reports:**<br>• Individual #2 – Report not completed 14 days prior to annual ISP meeting. (*Semi-Annual Report 3/22/2018 – 6/5/2018;* Date Completed: *6/19/2018; ISP meeting held on 6/19/2018).*<br><br>• Individual #30 – Report not completed 14 days prior to annual ISP meeting. (*Semi-Annual Report 3/29/2018 – 6/5/2018;* Date | | |

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| 5. The Case Manager must ensure at least quarterly that:<br>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<br><br>b. All applicable current Healthcare plans, Comprehensive Aspiration Risk Management Plan (CARMP), Positive Behavior Support Plan (PBSP or other applicable behavioral support plans (such as BCIP, PPMP, or RMP), and written Therapy Support Plans are in place in the residence and day service sites for individuals who receive Living Supports and/or Customized Community Supports (day services), and who have such plans.<br><br>6. The Case Managers will report all suspected abuse, neglect or exploitation as required by New Mexico Statutes;<br><br>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. | Completed: *6/15/2018; ISP meeting held on 6/19/2018).*<br><br>**Physical Semi - Annual Progress Reports:**<br>• Individual #12 – None found for 7/1/2017 – 6/30/2018.<br><br>**Nursing Semi - Annual Reports:**<br>• Individual #7 – None found for October 2017 – March 2018.<br><br>• Individual #22 – Report not completed 14 days prior to annual ISP meeting. (*Semi-Annual Report 6/29/2017 – 12/5/2017;* Date Completed: *12/20/2017; ISP meeting held on 12/6/2017).*<br><br>• Individual #23 – Report not completed 14 days prior to annual ISP meeting. (*Semi-Annual Report 9/1/2017 – 2/28/2018;* Date Completed: *12/6/2017; ISP meeting held on 12/12/2017).*<br><br>• Individual #28 – Report does not coincide with ISP year. (*Semi-Annual Report 11/1/2016 – 11/8/2017;* Date Completed: *11/10/2017; ISP term 3/1/2017 - 3/28/2018).*<br><br>• Individual #30 – None found for October 2017 – March 2018 and April 2018 – May 2018. | | |

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| 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:<br><br>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).<br><br>b. The Case Management Provider Agency will keep a copy of the RORI in the individual's record.<br><br>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.<br><br>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.<br><br>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. | | | |

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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS**<br>**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: | | | |

| Standard of Care | *Deficiencies* | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
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| ***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 # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up** | **Standard Level Deficiency** *(Modified as result of Pilot 1)* | | |
| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018<br>**Chapter 8 Case Management: 8.2.8 *Maintaining a Complete Client Record:***<br>The CM is required to maintain documentation for each person supported according to the following requirements:<br>3. The case file must contain the documents identified in Appendix A Client File Matrix.<br><br>**Chapter 3 Safeguards: 3.1.1 *Decision Consultation Process (DCP):*** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following:<br>1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to:<br>a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;<br>b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have | Based on record review, the Agency did not maintain a complete client record at the administrative office for 2 of 23 individuals.<br><br>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:<br><br>**Mammogram Exam:**<br>• Individual #12 - As indicated by the documentation reviewed, exam was completed on 3/27/2017. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found.<br><br>**Blood Levels:**<br>• Individual #28 - As indicated by the documentation reviewed, lab work was ordered on 12/28/2017. No documented evidence of follow-up found to indicate the lab work had been completed. | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| performed an evaluation such as a video-fluoroscopy;<br>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and<br>d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.<br><br>2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting:<br>a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation.<br>b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation.<br>c. Providers support the person/guardian to make an informed decision.<br>d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.<br><br>**Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The | | | |

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| contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.<br>DD Waiver Provider Agencies are required to adhere to the following:<br>8. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.<br>9. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable.<br>10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.<br>11. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.<br>12. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.<br>13. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.<br>14. All records pertaining to JCMs must be retained permanently and must be made available | | | |

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| to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.<br><br>**20.5.3 *Health Passport and Physician Consultation Form:*** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. Requirements for the *Health Passport* and *Physician Consultation* form are:<br>**1.** The Case Manager and Primary and Secondary Provider Agencies must communicate critical information to each other and will keep all required sections of Therap updated in order to have a current and thorough *Health Passport* and *Physician Consultation* Form available at all times. Required sections of Therap include the IDF, Diagnoses, and Medication History.<br>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015<br>**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;<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, | | | |

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| 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.<br><br>**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. | | | |

| Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans) | Standard Level Deficiency<br>*(Modified as result of Pilot 1)* | | |
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| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018<br>**Chapter 8 Case Management: 8.2.8**<br>***Maintaining a Complete Client Record:***<br>The CM is required to maintain documentation for each person supported according to the following requirements:<br>3. The case file must contain the documents identified in Appendix A Client File Matrix.<br><br>**Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.<br>DD Waiver Provider Agencies are required to adhere to the following:<br>15. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.<br>16. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable.<br>17. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed | Based on record review, the Agency did not maintain a complete client record at the administrative office for 1 of 23 individuals.<br><br>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:<br><br>**Health Care Plans:**<br>• *Bowel/Bladder*<br>  • Individual #17 – Review of the Agency case file found evidence of a Healthcare Plan dated 2/3/2017. The Health Care Plan found was not current.<br><br>• *Constipation*<br>  • Individual #17 – Review of the Agency case file found evidence of a Healthcare Plan dated 1/27/2017. The Health Care Plan found was not current.<br><br>• *Home Health Care*<br>  • Individual #17 – Review of the Agency case file found evidence of a Healthcare Plan dated 2/3/2017. The Health Care Plan found was not current.<br><br>• *Hydration*<br>  • Individual #17 – Review of the Agency case file found evidence of a Healthcare Plan dated 2/3/2017. The Health Care Plan found was not current.<br><br>• *Neurology*<br>  • Individual #17 – Review of the Agency case file found evidence of a Healthcare Plan | **Provider:**<br>**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?)*: →<br><br>**Provider:**<br>**Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: → | |

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| settings.<br>18. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.<br>19. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.<br>20. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.<br>21. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.<br><br>**Chapter 3 Safeguards: 3.1.1 *Decision Consultation Process (DCP):*** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following:<br>2. The DCP is used when a person or his/her guardian/healthcare decision maker has | dated 1/8/2017. The Health Care Plan found was not current.<br><br>• *Paralysis*<br>  • Individual #17 – Review of the Agency case file found evidence of a Healthcare Plan dated 2/3/2017. The Health Care Plan found was not current.<br><br>• *Skin/Wound*<br>  • Individual #17 – Review of the Agency case file found evidence of a Healthcare Plan dated 1/8/2017. The Health Care Plan found was not current.<br><br>• *Spasticity*<br>  • Individual #17 – Review of the Agency case file found evidence of a Healthcare Plan dated 2/3/2017. The Health Care Plan found was not current. | | |

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| concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to:<br>a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;<br>b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy;<br>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and<br>d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.<br><br>2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting:<br>c. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits | | | |

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| of the recommendation.<br>d. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation.<br>c. Providers support the person/guardian to make an informed decision.<br>d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015<br>**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;<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**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.<br><br>**D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case | | | |

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| 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:<br>(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;<br>(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);<br>(3) Progress notes and other service delivery documentation;<br>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;<br>(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;<br>(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<br>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.<br>(8) The receiving Provider Agency shall be provided at a minimum the following records | | | |

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| whenever an individual changes provider agencies:<br>(a) Complete file for the past 12 months;<br>(b) ISP and quarterly reports from the current and prior ISP year;<br>(c) Intake information from original admission to services; and<br>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital. | | | |

| Standard of Care | *Deficiencies* | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
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| ***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 Deficient Practices Found** | | |
| Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018<br>**Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following:<br>1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing.<br>2. Comprehensive documentation of direct service delivery must include, at a minimum:<br>a. the agency name;<br>b. the name of the recipient of the service;<br>c. the location of the service;<br>d. the date of the service;<br>e. the type of service;<br>f. the start and end times of the service;<br>g. the signature and title of each staff member who documents their time; and<br>h. the nature of services.<br>3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer.<br><br>**21.9.2 Requirements for Monthly Units:**<br>For services billed in monthly units, a Provider Agency must adhere to the following: | Based on record review, the Agency maintained all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving for 23 of 23 individuals.<br><br>*Progress notes and billing records supported billing activities for the months of March, April and May 2018.* | | |

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| 1. A month is considered a period of 30 calendar days.<br>2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed.<br>3. Monthly units can be prorated by a half unit.<br>4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit. | | | |

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| Date: | September 27, 2018 |
| To: | Gabriela Ramos, Executive Director |
| Provider: | Carino Case Management Inc |
| Address: | 2701 San Pedro Dr NE #10 |
| State/Zip: | Albuquerque, New Mexico 87110 |
| E-mail Address: | gbramos@comcast.net |
| Region: | Metro |
| Survey Date: | June 22 - 29, 2018 |
| Program Surveyed: | Developmental Disabilities Waiver |
| Service Surveyed: | ***2007, 2012 & 2018 :*** Case Management |
| Survey Type: | Routine |

Dear Ms. Gabriela Ramos:

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

**The Plan of Correction process is now complete.**

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.18.4.DDW.D2326.5.RTN.09.18.270