REVISED by IRF 2/5/2019

Date: December 5, 2018

To: Kristin Pasquini-Johnson, Co-Owner / Case Manager Supervisor / Quality Assurance Director

Provider: Unidas Case Management Inc.
Address: 205 W Boutz
City, State, Zip: Las Cruces, New Mexico 88005

E-mail Address: kpjohnson@unidascm.org

Region: Southwest
Survey Date: November 2 - 9, 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 Member: Amanda Castaneda, MPA, Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau; Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Monica Valdez, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Beverly Estrada, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Kristin Pasquini-Johnson;

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

Determination of Compliance:

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

Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags: This determination is based on noncompliance with one to five (1 – 5) Condition of Participation Level Tags *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File
- Tag # 4C02 Scope of Services - Primary Freedom of Choice
- Tag # 4C12 Monitoring & Evaluation of Services
- Tag # 4C15.1 Service Monitoring: Annual / Semi-Annual Reports & Provider Semi – Annual / Quarterly Report
- Tag # 4C07.2 Person Centered Assessment and Career Development Plan
- Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)
- Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)

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:	November 2, 2018
Contact:	**Unidas Case Management Inc.** Krisitin Pasquini-Johnson, Co-Owner / Case Manager Supervisor / Quality Assurance Director **DOH/DHI/QMB** Wolf Krusemark, BFA, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	November 5, 2018
Present:	**Unidas Case Management Inc.** Kristin Pasquini Johnson, Co-Owner / Case Manager Supervisor / Quality Assurance Director Eric Hankla, Co-Owner / Case Manager Supervisor / Financial Director **DOH/DHI/QMB** Wolf Krusemark, BFA, Team Lead / Healthcare Surveyor Lora Norby, Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor
Exit Conference Date:	November 7, 2018
Present:	**Unidas Case Management Inc.** Kristin Pasquini-Johnson, Co-Owner / Case Manager Supervisor / Quality Assurance Director Eric Hankla, Co-Owner / Case Manager Supervisor / Financial Director Scott Newland, Co-Owner / Case Manager Supervisor / Operations Manager **DOH/DHI/QMB** Wolf Krusemark, BFA, Team Lead / Healthcare Surveyor Lora Norby, Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor **DDSD Regional Office** Cheryl Dunfee, Case Management Coordinator (SW Region)
Administrative Locations Visited	1
Total Sample Size	13 2 - *Jackson* Class Members 11 - Non-*Jackson* Class Members
Persons Served Records Reviewed	13
Case Manager Interviewed	5
Case Manager Records Reviewed	5
Total # of Secondary Freedom of Choices	60
Administrative Interviews	1

Administrative Processes and Records Reviewed:

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

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

Attachment A

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

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

POC Document Submission Requirements

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

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

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

Attachment B

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

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

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

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

Conditions of Participation (CoPs)

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

Service Domains and CoPs for <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%:

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

<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 with 75% to 100% of the survey sample affected in any tag.

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

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

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 **Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix. **Chapter 20: Provider Documentation and Client Records: 20.2** Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic	Based on record review, the Agency did not maintain a complete client record at the administrative office for 2 of 13 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Individual Data Form:** • Not Current (#9, 10) **Physical Therapy Evaluation:** • Not Current (#9) **Speech/Language Therapy Evaluation:** • Not Found (#9)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all 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. 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. 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. 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. **20.5.1 Individual Data Form (IDF):** The Individual Data Form provides an overview of demographic information as well as other key personal, programmatic, insurance, and health related information. It lists medical information; assistive technology or adaptive equipment; diagnoses; allergies; information about whether a guardian or advance directives are in place; information about behavioral and health related needs; contacts of Provider Agencies and team 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. **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: 1. Discussion and decisions about non-health related recommendations are documented on the Team Justification form. 2. The Team Justification form documents that the person/guardian or team has considered the recommendations and has decided: a. to implement the recommendation; b. to create an action plan and revise the ISP, if necessary; or c. not to implement the recommendation currently. 3. All DD Waiver Provider Agencies participate in information gathering, IDT meeting attendance, and accessing supplemental resources if needed and desired. 4. The CM ensures that the Team Justification Process is followed and complete.			

Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components *Modified by IRF 2/4/2019*	Condition of Participation Level Deficiency		
NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY. **NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS.** **NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.** Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **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. **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. **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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain a complete client record at the administrative office for 4 of 13 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Signature Page:** • Not Fully Constituted IDT (No evidence of Nurse involvement) (#1, 10) *Note: Finding for Individual #1 removed by IRF.* • Not Fully Constituted IDT (No evidence of Physical Therapist involvement) (#9) • Not Fully Constituted IDT (No evidence of Speech Language Pathologist involvement) (#9) *Note: Finding for Individual #9 upheld by IRF.* • Not Fully Constituted IDT (No evidence of Occupational Therapist involvement) (#10, 12) *Note: Finding for Individual #10 removed by IRF. Finding for Individual #12 upheld.* • Not Fully Constituted IDT (No evidence of Behavior Support Consultant involvement) (#10, 11) *Note: Finding for Individual #11 upheld by IRF.* • Not Fully Constituted IDT (No evidence of Direct Support Personnel) (#11)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

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. The ISP is completed by the CM with the IDT input and must be completed according to the following requirements: 1. DD Waiver Provider Agencies should not recommend service type, frequency, and amount (except for required case management services) on an individual budget prior to the Vision Statement and Desired Outcomes being developed. 2. The person does not require IDT agreement/approval regarding his/her dreams, aspirations, and desired long-term outcomes. 3. When there is disagreement, the IDT is required to plan and resolve conflicts in a manner that promotes health, safety, and quality of life through consensus. Consensus means a state of general agreement that allows members to support the proposal, at least on a trial basis. 4. A signature page and/or documentation of participation by phone must be completed. 5. The CM must review a current Addendum A and DHI ANE letter with the person and Court appointed guardian or parents of a minor, if applicable. **6.6.3 Additional Requirements for Adults:** Because children have access to other funding sources, a larger array of services are available to adults than to children through the DD Waiver. (See Chapter 7: Available Services and Individual Budget Development). The ISP Template for adults is also more extensive, including Action Plans, Teaching and Support Strategies (TSS), Written Direct Support Instructions (WDSI), and Individual Specific Training (IST) requirements. **6.6.3.1. Action Plan:** Each Desired Outcome requires an Action Plan. The Action Plan addresses individual strengths and capabilities in reaching Desired Outcomes. Multiple service types	**ISP Teaching and Support Strategies:** **Individual #9** *TSS not found for Live Outcome Statement / Action Steps:* • "...will assist staff in folding his laundry 1 x weekly." • "...will hang up his laundry 1 x weekly." *TSS not found for Work/Learn Outcome Statement / Action Steps:* • "...will create art project 1 x monthly." **Individual #10** *TSS not found for work/learn* Outcome Statement / *Action Steps:* • "...will select gross motor activity 3 x weekly." **Individual #11** *TSS not found for Live Outcome Statement / Action Steps:* • *"...will work on/create his artwork."*		

may be included in the Action Plan under a single Desired Outcome. Multiple Provider Agencies can and should be contributing to Action Plans toward each Desired Outcome. 1. Action Plans include actions the person will take; not just actions the staff will take. 2. Action Plans delineate which activities will be completed within one year. 3. Action Plans are completed through IDT consensus during the ISP meeting. 4. Action Plans must indicate under "Responsible Party" which DSP or service provider (i.e. Family Living, CCS, etc.) are responsible for carrying out the Action Step. **6.6.3.2 Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI):** After the ISP meeting, IDT members conduct a task analysis and assessments necessary to create effective TSS and WDSI to support those Action Plans that require this extra detail. All TSS and WDSI should support the person in achieving his/her Vision. **6.6.3.3 Individual Specific Training in the ISP:** The CM, with input from each DD Waiver Provider Agency at the annual ISP meeting, completes the IST requirements section of the ISP form listing all training needs specific to the individual. Provider Agencies bring their proposed IST to the annual meeting. The IDT must reach a consensus about who needs to be trained, at what level (awareness, knowledge or skill), and within what timeframe. (See Chapter 17.10 Individual-Specific Training for more information about IST.) **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT			

members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **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. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.			

Tag # 4C02 Scope of Services - Primary Freedom of Choice	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 8 Case Management:** **8.1 General Definition and Intent of Case Management Services:** Case Management services are person-centered and intended to support people to pursue their desired life outcomes while gaining independence and access to needed services and supports. The essential elements of Case Management include activities related to advocacy, assessment, planning, linking, and monitoring. DD Waiver CMs also play an important role in allocation, annual medical and financial recertification, record keeping, and budget approvals. CMs must maintain a current and thorough working knowledge of the DD Service Standards and community resources. In addition to paid supports, Case Management services also emphasize and promote the use of natural and generic supports to address a person's assessed needs. **8.2.7 *Monitoring and Evaluating Service Delivery:*** 13. The CM must monitor utilization of budgets by reviewing in the Medicaid Web Portal on a monthly basis in preparation for site visits. The CM uses the information to have informed discussions with the person/guardian about high or low utilization and to follow up with any action that may be needed to assure services are provided as outlined in the ISP with respect to: quantity, frequency and duration. Follow up action may include, but not be limited to: e. documenting extraordinary circumstances; f. convening the IDT to submit a revision to the ISP and budget as necessary; g. working with the provider to align service provision with ISP and using the RORA process if there is no resolution from the provider; and h. reviewing the SFOC process with the person and guardian, if applicable.	Based on record review, the Agency did not maintain documentation assuring individuals obtained all services through the freedom of choice process for 3 of 13 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Primary Freedom of Choice:** • Not Found (#9, 10, 11)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

Tag # 4C07.2 Person Centered Assessment and Career Development Plan	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 8 Case Management: 8.2.8 *Maintaining a Complete Client Record:*** The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix. **Chapter 11 Community Inclusion: 11.4 Person Centered Assessments (PCA) and Career Development Plans:** Agencies who are providing CCS and/or CIE to people with I/DD are required to complete a person-centered assessment. A person-centered assessment (PCA) is an instrument used to identify individual needs and strengths to be addressed in the person's ISP. A PCA is a PCP tool that is intended to be used for the service agency to get to know the person whom they are supporting. It should be used to guide services for the person. A career development plan, developed by the CIE Provider Agency, must be in place for job seekers or those already working to outline the tasks needed to obtain, maintain, or seek advanced opportunities in employment. For those who are employed, the career development plan addresses topics such as a plan to fade paid supports from the worksite or strategies to improve opportunities for career advancement. CCS and CIE Provider Agencies must adhere to the following requirements related to a PCA and Career Development Plan: 1. A person-centered assessment should contain, at a minimum: a. information about the person's background and status; b. the person's strengths and interests; c. conditions for success to integrate into the community, including conditions for job success (for those who are working or wish to work); and	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 13 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Career Development Plan:** • Not Current (#9)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

d. support needs for the individual. 2. The agency must have documented evidence that the person, guardian, and family as applicable were involved in the person-centered assessment. 3. Timelines for completion: The initial PCA must be completed within the first 90 calendar days of the person receiving services. Thereafter, the Provider Agency must ensure that the PCA is reviewed and updated annually. An entirely new PCA must be completed every five years. If there is a significant change in a person's circumstance, a new PCA may be required because the information in the PCA may no longer be relevant. A significant change may include but is not limited to: losing a job, changing a residence or provider, and/or moving to a new region of the state. 4. If a person is receiving more than one type of service from the same provider, one PCA with information about each service is acceptable. 5. Changes to an updated PCA should be signed and dated to demonstrate that the assessment was reviewed. 6. A career development plan is developed by the CIE provider and can be a separate document or be added as an addendum to a PCA. The career development plan should have specific action steps that identify who does what and by when. **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.			

Tag # 4C12 Monitoring and Evaluation of Services	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix. **8.2.7 Monitoring and Evaluating Service Delivery:** The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health and safety of the person. Monitoring and evaluation activities include the following requirements: 1. The CM is required to meet face-to-face with adult DD Waiver participants at least 12 times annually (one time per month) to bill for a monthly unit. 2. JCMs require two face-to-face contacts per month to bill the monthly unit, one of which must occur at a location in which the person spends the majority of the day (i.e., place of employment, habilitation program), and the other contact must occur at the person's residence. 3. Parents of children on the DD Waiver must receive a minimum of four visits per year, as established in the ISP. The parent is responsible for monitoring and evaluating services provided in the months case management services are not received. 4. No more than one IDT Meeting per quarter may count as a face-to-face contact for adults (including JCMs) living in the community. 5. For non-JCMs, face-to-face visits must occur as follows: a. At least one face-to-face visit per quarter shall	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 2 of 13 individuals. **Review of the Agency Individual case-files revealed face-to-face visits were not being completed as required by standards (#2, #5, a, b, and c) for the following individuals:** **Individual #5** (Jackson) No site visit was noted for the month of 6/2018 • 6/11/2018 - 3:45pm – home. • 6/26/2018 - 3:00pm – home. **Individual #8** (Jackson) No site visits were noted for the months of 10/2017 & 11/2017. • 10/10/2017 - 11:15am – site. • 10/31/2017 - 11:30am – site. • 11/15/2017 - 4:30pm – home. • 11/29/2017 - 5:45pm – home.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

occur at the person's home for people who receive a Living Supports or CIHS. 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. 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. d. The CM considers preferences of the person when scheduling face-to face-visits in advance. e. Face-to-face visits may be unannounced depending on the purpose of the monitoring. 6. The CM must monitor at least quarterly: 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 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. 7. When risk of significant harm is identified, the CM follows. the standards outlined in Chapter 18: Incident Management System. 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. 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. 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. 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. 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. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 4 (CMgt) 2. Service Requirements: D. Monitoring And Evaluation of Service Delivery:** 1. The Case Manager shall use a formal ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the individual specified in the ISP. 2. Monitoring and evaluation activities shall include, but not be limited to: a. The case manager is required to meet face-to-face with adult DDW participants at least twelve (12) times annually (1 per month) as described in the ISP. b. Parents of children served by the DDW may receive a minimum of four (4) visits per year, as established in the ISP. When a parent chooses fewer than twelve (12) annual units of case management, the parent is responsible for the monitoring and evaluating services provided in the months case management services are not received. c. No more than one (1) IDT Meeting per quarter may count as a face- to-face contact for adults (including Jackson Class members) living in the			

community. d. Jackson Class members require two (2) face- to-face contacts per month, one (1) of which must occur at a location in which the individual spends the majority of the day (i.e., place of employment, habilitation program); and one must occur at the individual's residence. e. For non-Jackson Class members, who receive a Living Supports service, at least one face-to-face visit shall occur at the individual's home quarterly; and at least one face- to-face visit shall occur at the day program quarterly if the individual receives Customized Community Supports or Community Integrated Employment services. The third quarterly visit is at the discretion of the Case Manager. 3. It is appropriate to conduct face-to-face visits with the individual either during times when the individual is receiving services, or times when the individual is not receiving a service. The preferences of the individual shall be taken into consideration when scheduling a visit. 4. Visits may be scheduled in advance or be unannounced, depending on the purpose of the monitoring of services. 5. The Case Manager must ensure at least quarterly that: a. Applicable Medical Emergency Response Plans and/or BCIPs are in place in the residence and at the day services location(s) for all individuals who have chronic medical condition(s) with potential for life threatening complications, or individuals with behavioral challenge(s) that pose a potential for harm to themselves or others; and b. All applicable current Healthcare plans, Comprehensive Aspiration Risk Management Plan (CARMP), Positive Behavior Support Plan (PBSP or other applicable behavioral support plans (such as BCIP, PPMP, or RMP), and written Therapy			

Support Plans are in place in the residence and day service sites for individuals who receive Living Supports and/or Customized Community Supports (day services), and who have such plans. 6. The Case Managers will report all suspected abuse, neglect or exploitation as required by New Mexico Statutes; 7. If concerns regarding the health or safety of the individual are documented during monitoring or assessment activities, the Case Manager shall immediately notify appropriate supervisory personnel within the Provider Agency and document the concern. In situations where the concern is not urgent the provider agency will be allowed up to fifteen (15) business days to remediate or develop an acceptable plan of remediation. 8. If the Case Manager's reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office: a. Submit the DDSD Regional Office Request for Intervention form (RORI); including documentation of requests and attempts (at least two) to resolve the issue(s). b.The Case Management Provider Agency will keep a copy of the RORI in the individual's record. 9. Conduct an online review in the Therap system to ensure that electronic Comprehensive Health Assessment Tools (e-CHATs) and Health Passports are current for those individuals selected for the Quarterly ISP QA Review. 10. The Case Manager will ensure Living Supports are delivered in accordance with standards, including the minimum of thirty (30) hours per week of planned activities outside the residence. If the			

planned activities are not possible due to the needs of the individual, the ISP will contain an outcome that addresses an appropriate level of community integration for the individual. These activities do not need to be limited to paid supports but may include independent or leisure activities with natural supports appropriate to the needs of individual. 11. For individuals with Intensive Medical Living Services, the IDT is not required to plan for at least thirty (30) hours per week of planned activities outside of the residence. 12. Case Managers shall facilitate and maintain communication with the individual, guardian, his/her representative, other IDT members, providers and other relevant parties to ensure the individual receives maximum benefit from his/her services. The Case Managers ensures any needed revisions to the service plan are made, where indicated. Concerns identified through communication with teams that are not remedied within a reasonable period of time shall be reported in writing to the respective DDSD Regional Office on a RORI form. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS: J. Case Manager Monitoring and Evaluation of Service Delivery** (1) The Case Manager shall use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual as specified in the ISP. (2) Monitoring and evaluation activities shall include, but not be limited to: (a) Face-To-Face Contact: A minimum of twelve (12) face-to-face contact visits annually (1 per month) is required to occur between the Case			

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

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

Tag # 4C15.1 Service Monitoring - Annual / Semi-Annual Reports & Provider Semi - Annual / Quarterly Reports	Standard Level Deficiency		
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix. **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	Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 3 of 10 individuals. Review of the Agency individual case files revealed no evidence of quarterly/bi-annual reports for the following: **Supported Living Semi-Annual Reports:** • Individual #9 - None found for 7/2017 – 9/2017 *(Term of ISP 1/14/2017 – 1/15/2018. ISP meeting held 10/10/2017)* and 1/2018 - 6/2018 *(Term of ISP 1/15/2018 - 1/14/2019).* • Individual #10 - None found for 3/2018 – 8/2018. *(Term of ISP 3/1/2018 - 2/28/2019).* **Customized Community Supports Semi-Annual Reports:** • Individual #2 - None found for 6/2017 – 8/2017 *(Term of ISP 12/2016 - 12/2017. ISP meeting held 9/17/2017)* and 12/2017 - 5/2018 *(Term of ISP 12/2017 - 12/2018). Note: Due diligence provided. No plan of correction required.* • Individual #9 - None found for 7/2017 – 9/2017 *(Term of ISP 1/14/2017 – 1/15/2018. ISP meeting held 10/10/2017)* and 1/2018 - 6/2018 *(Term of ISP 1/15/2018 - 1/14/2019).* • Individual #10 - None found for 3/2018 – 8/2018. *(Term of ISP 3/1/2018 - 2/28/2019).*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

responsible for monitoring the health and safety of the person... Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 4 (CMgt) 2. Service Requirements:** **C. Individual Service Planning:** The Case Manager is responsible for ensuring the ISP addresses all the participant's assessed needs and personal goals, either through DDW waiver services or other means. The Case Manager ensures the ISP is updated/revised at least annually; or when warranted by changes in the participant's needs. 1. The ISP is developed through a person-centered planning process in accordance with the rules governing ISP development [7.26.5 NMAC] and includes: b. Sharing current assessments, including the SIS assessment, semi-annual and quarterly reports from all providers, including therapists and BSCs. Current assessment shall be distributed by the authors to all IDT members at least fourteen (14) calendar days prior to the annual IDT Meeting, in accordance with the DDSD Consumer File Matrix Requirements. The Case Manager shall notify all IDT members of the annual IDT meeting at least twenty-one (21) calendar days in advance: **D. Monitoring And Evaluation of Service Delivery:** 1. The Case Manager shall use a formal ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the individual specified in the ISP. 5. The Case Manager must ensure at least quarterly that:	**Community Integrated Employment Semi-Annual Reports:** • Individual #2 - None found for 6/2017 – 8/2017 *(Term of ISP 12/2016 - 12/2017. ISP meeting held 9/7/2017)* and 12/2017 - 5/2018 *(Term of ISP 12/2017 - 12/2018). Note: Due diligence provided. No plan of correction required.* • Individual #9 - None found for 7/2017 – 9/2017 *(Term of ISP 1/14/2017 – 1/15/2018. ISP meeting held 10/10/2017)* and 1/2018 - 6/2018 *(Term of ISP 1/15/2018 - 1/14/2019).* **Behavior Support Consultation Semi-Annual Progress Reports:** • Individual #10 - None found for 8/2017 – 11/2017. *(Term of ISP 3/1/2018 - 2/28/2019. ISP meeting held 12/5/2017).* • Individual #11 - None found for 9/2017 – 3/2018. *(Term of ISP 9/14/2017 - 9/13/2018).*		

a. Applicable Medical Emergency Response Plans and/or BCIPs are in place in the residence and at the day services location(s) for all individuals who have chronic medical condition(s) with potential for life threatening complications, or individuals with behavioral challenge(s) that pose a potential for harm to themselves or others; and b. All applicable current Healthcare plans, Comprehensive Aspiration Risk Management Plan (CARMP), Positive Behavior Support Plan (PBSP or other applicable behavioral support plans (such as BCIP, PPMP, or RMP), and written Therapy Support Plans are in place in the residence and day service sites for individuals who receive Living Supports and/or Customized Community Supports (day services), and who have such plans. 6. The Case Managers will report all suspected abuse, neglect or exploitation as required by New Mexico Statutes; 7. If concerns regarding the health or safety of the individual are documented during monitoring or assessment activities, the Case Manager shall immediately notify appropriate supervisory personnel within the Provider Agency and document the concern. In situations where the concern is not urgent the provider agency will be allowed up to fifteen (15) business days to remediate or develop an acceptable plan of remediation. 8. If the Case Manager's reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office:			

a. Submit the DDSD Regional Office Request for Intervention form (RORI); including documentation of requests and attempts (at least two) to resolve the issue(s). b. The Case Management Provider Agency will keep a copy of the RORI in the individual's record. 9. Conduct an online review in the Therap system to ensure that electronic Comprehensive Health Assessment Tools (e-CHATs) and Health Passports are current for those individuals selected for the Quarterly ISP QA Review. 10. The Case Manager will ensure Living Supports are delivered in accordance with standards, including the minimum of thirty (30) hours per week of planned activities outside the residence. If the planned activities are not possible due to the needs of the individual, the ISP will contain an outcome that addresses an appropriate level of community integration for the individual. These activities do not need to be limited to paid supports but may include independent or leisure activities with natural supports appropriate to the needs of individual. 11. For individuals with Intensive Medical Living Services, the IDT is not required to plan for at least thirty (30) hours per week of planned activities outside of the residence. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS** **C. Quality Assurance Requirements:** Case Management Provider Agencies will use an Internal Quality Assurance and Improvement Plan that must be submitted to and reviewed by			

the Statewide Case Management Coordinator, that shall include but is not limited to the following: (1) Case Management Provider Agencies are to: (a) Use a formal ongoing monitoring protocol that provides for the evaluation of quality, effectiveness and continued need for services and supports provided to the individual. This protocol shall be written and its implementation documented. (b) Assure that reports and ISPs meet required timelines and include required content. (c) Conduct a quarterly review of progress reports from service providers to verify that the individual's desired outcomes and action plans remain appropriate and realistic. (i) If the service providers' quarterly reports are not received by the Case Management Provider Agency within fourteen (14) days following the end of the quarter, the Case Management Provider Agency is to contact the service provider in writing requesting the report within one week from that date. (ii) If the quarterly report is not received within one week of the written request, the Case Management Provider Agency is to contact the respective DDSD Regional Office in writing within one business day for assistance in obtaining required reports. (d) Assure at least quarterly that Crisis Prevention/Intervention Plans are in place in the residence and at the Provider Agency of the Day Services for all individuals who have chronic medical condition(s) with potential for life threatening complications and/or who have behavioral challenge(s) that pose a potential for harm to themselves or others. (e) Assure at least quarterly that a current Health Care Plan (HCP) is in place in the residence and day service site for individuals who receive Community Living or Day Services			

and who have a HAT score of 4, 5, or 6. During face-to-face visits and review of quarterly reports, the Case Manager is required to verify that the Health Care Plan is being implemented. (f) Assure that Community Living Services are delivered in accordance with standards, including responsibility of the IDT Members to plan for at least 30 hours per week of planned activities outside the residence. If this is not possible due to the needs of the individual, a goal shall be developed that focuses on appropriate levels of community integration. These activities do not need to be limited to paid supports but may include independent or leisure activities appropriate to the individual. (g) Perform annual satisfaction surveys with individuals regarding case management services. A copy of the summary is due each December 10th to the respective DDSD Regional Office, along with a description of actions taken to address suggestions and problems identified in the survey. (h) Maintain regular communication with all providers delivering services and products to the individual. (i) Establish and implement a written grievance procedure. (j) Notify appropriate supervisory personnel within the Provider Agency if concerns are noted during monitoring or assessment activities related to any of the above requirements. If such concerns are not remedied by the Provider Agency within a reasonable mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office and/or DHI as appropriate to the nature of the concern. This does not preclude Case Managers' obligations to report abuse, neglect or exploitation as required by New Mexico Statute. (k) Utilize and submit the "Request for DDSD			

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

Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)	Standard Level Deficiency		
NMAC 7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: A.The case manager shall provide copies of the completed ISP, with all relevant service provider strategies attached, within fourteen (14) days of ISP approval to: (1) the individual; (2) the guardian (if applicable); (3) all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons; (4) all other IDT members in attendance at the meeting to develop the ISP; (5) the individual's attorney, if applicable; (6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies; (7) for all developmental disabilities Medicaid waiver recipients, including *Jackson* class members, a copy of the completed ISP containing all the information specified in 7.26.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD; (8) for *Jackson* class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the *Jackson* lawsuit office of the DDSD. B.Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review and/or interview the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 2 of 13 Individual: **No Evidence found indicating ISP was distributed:** • Individual #3: ISP was not provided to the Individual, Guardian and/or other Providers. • Individual #8: ISP was not provided to the Individual, Guardian and/or other Providers.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 6 Individual Service Plan (ISP) 6.7 Completion and Distribution of the ISP:** The CM is required to assure all elements of the ISP and companion documents are completed and distributed to the IDT. However, DD Waiver Provider Agencies share responsibility to contribute to the completion of the ISP. The ISP must be completed and approved prior to the expiration date of the previous ISP term. Within 14 days of the approved ISP and when available, the CM distributes the ISP to the DDSD Regional Office, the DD Waiver Provider Agencies with a SFOC, and to all IDT members requested by the person.			

Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)	Standard Level Deficiency		
NMAC 7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: A. The case manager shall provide copies of the completed ISP, with all relevant service provider strategies attached, within fourteen (14) days of ISP approval to: (1) the individual; (2) the guardian (if applicable); (3) all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons; (4) all other IDT members in attendance at the meeting to develop the ISP; (5) the individual's attorney, if applicable; (6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies; (7) for all developmental disabilities Medicaid waiver recipients, including *Jackson* class members, a copy of the completed ISP containing all the information specified in 7.26.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD; (8) for *Jackson* class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the *Jackson* lawsuit office of the DDSD. B. Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.	Based on record review and/or interview the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 2 of 13 Individual: • Individual #3 • Individual #5	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 6 Individual Service Plan (ISP) 6.7 Completion and Distribution of the ISP:** The CM is required to assure all elements of the ISP and companion documents are completed and distributed to the IDT. However, DD Waiver Provider Agencies share responsibility to contribute to the completion of the ISP. The ISP must be completed and approved prior to the expiration date of the previous ISP term. Within 14 days of the approved ISP and when available, the CM distributes the ISP to the DDSD Regional Office, the DD Waiver Provider Agencies with a SFOC, and to all IDT members requested by the person.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Health, Safety and Welfare **-** *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up ***Modified by IRF 2/4/2019***	**Condition of Participation Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix. **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: 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: 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; b. clinical recommendations made by	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain a complete client record at the administrative office for 4 of 13 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Auditory Exam:** • Individual #9 - As indicated by the documentation reviewed, exam was completed on 4/30/2015. Follow-up was to be completed in 3 years. No documented evidence of the follow-up being completed was found. *Note: Auditory exam for Individual #9 removed by IRF.* • Individual #11 - As indicated by the documentation reviewed, exam was completed on 6/9/2018. Follow-up was to be completed in 2 months. No documented evidence of the follow-up being completed was found. **Dental Exam:** • Individual #5 - As indicated by the documentation reviewed, exam was completed on 10/23/2017. Follow-up was to be completed in 12 months. No documented	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →* **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →*	

registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 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: 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. 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. c. Providers support the person/guardian to make an informed decision. 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. **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	evidence of the follow-up being completed was found. *(Note: Exam scheduled for 11/6/2018 during on site survey).* *Note: Dental exam for Individual #5 removed by IRF.* • Individual #8 - As indicated by the documentation reviewed, exam was completed on 6/8/2017. Follow-up was to be completed in 12 months. No documented evidence of the follow-up being completed was found. *(Note: Exam scheduled for 12/6/2018 during on site survey).* *Note: Dental exam for Individual #8 upheld by IRF.* **Psychological Assessment:** • Individual #5 - As indicated by documentation reviewed assessment was completed on 10/9/2018. Follow-up was to be completed on 10/22/2018. No documented evidence of the assessment being completed was found. *Note: Psychological Assessment for Individual #5 removed by IRF.* **Vision Exam:** • Individual #3 - As indicated by the documentation reviewed, exam was completed on 7/31/2017. Follow-up was to be completed in 12 months. No documented evidence of the follow-up being completed was found. *(Note: Exam scheduled for 11/28/2018 during on site survey).* • Individual #7 - As indicated by the documentation reviewed, exam was completed on 4/27/2017. Follow-up was to be completed in 12 months. No documented evidence of the follow-up being completed		

contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all 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. 1. 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. 2. 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. 3. All records pertaining to JCMs must be	was found. *(Note: Exam scheduled for 12/6/2018 during on site survey).*		

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. 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: 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.			

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag # 1A12 All Services Reimbursement	**No Deficient Practices Found**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **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: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and h. the nature of services. 3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer. **21.9.2 Requirements for Monthly Units:** 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 Case Management for 15 of 15 individuals. *Progress notes and billing records supported billing activities for the months of June, July and August 2018*		

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

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date: February 13, 2019

To: Kristin Pasquini-Johnson, Co-Owner / Case Manager Supervisor / Quality Assurance Director
Provider: Unidas Case Management Inc.
Address: 205 W Boutz
City, State, Zip: Las Cruces, New Mexico 88005

E-mail Address: kpjohnson@unidascm.org

Region: Southwest
Survey Date: November 2 - 9, 2018
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2007, 2012, 2018:*** Case Management

Survey Type: Routine

Dear Ms. Kristin Pasquini-Johnson;

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.19.2.DDW.D3434.3.RTN.09.19.044