NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

Date:	August 27, 2021
To:	Andrew Starck, Owner/Director
Provider: Address: State/Zip:	Amigo Case Management Inc. 2610 San Mateo Blvd. NE, Suite B Albuquerque, New Mexico 87110-3162
E-mail Address:	andrew@amigocm.com
Region: Survey Date:	Metro and Southwest Month June 21 – July 2, 2021
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Case Management
Survey Type:	Routine
Team Leader:	Joshua Burghart, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Heather Driscoll, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Caitlin Wall, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Beverly Estrada, ADN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Sally Rel, MS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Andrew Starck;

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.

Non-Compliance: This determination is based on noncompliance with 17 or more total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level tag or any amount of Standard Level Tags with 6 or more 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 # 4C07 Individual Service Planning *(Visions, measurable outcome, action steps)*
- Tag # 4C12 Monitoring & Evaluation of Services
- Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)
- Tag # 4C04 Assessment Activities
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File)
- Tag # 1A08.4 Assistive Technology Inventory List
- Tag # 4C02 Scope of Services - Primary Freedom of Choice
- Tag # 4C07.1 Individual Service Planning – Paid Services
- Tag # 4C07.2 Person Centered Assessment and Career Development Plan
- Tag # 4C08 ISP Development Process
- Tag # 4C09 Secondary FOC
- Tag # 4C12.1 Monitoring & Evaluation of Services (IDT Meetings for Significant Life Events)
- Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)

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: Monica Valdez, Plan of Correction Coordinator in any of the following ways:**
   a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108

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
1474 Rodeo Road
Santa Fe, New Mexico 87505

If you have questions and would like to speak with someone at HSD/OIG/PIU, please contact:

Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)

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:

ATTN: QMB Bureau Chief
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 contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@state.nm.us 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,

Joshua Burghart

Joshua Burghart, BS
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	June 21, 2021
Contact:	**Amigo Case Management Inc.** Andrew Starck, Owner/Director **DOH/DHI/QMB** Joshua Burghart, BS, Team Lead/Healthcare Surveyor Heather Driscoll, AA, Healthcare Surveyor Caitlin Wall, BA, BSW, Healthcare Surveyor Beverly Estrada, ADN, Healthcare Surveyor Sally Rel, MS, Healthcare Surveyor
On-site Entrance Conference Date:	*Entrance Conference was waived by provider*
Exit Conference Date:	July 2, 2021
Present:	**Amigo Case Management Inc.** Andrew Starck, Owner/Director Michele Mills, Administrative Assistant **DOH/DHI/QMB** Joshua Burghart, BS, Team Lead/Healthcare Surveyor Heather Driscoll, AA, Healthcare Surveyor Caitlin Wall, BA, BSW, Healthcare Surveyor Beverly Estrada, ADN, Healthcare Surveyor Sally Rel, MS, Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor **DDSD - Metro Regional Office** Jenni McNab, Assistant Director Steven Gutierrez, Case Manager Coordinator
Administrative Locations Visited:	0 (*Note: No administrative locations visited due to COVID-19 Public Health Emergency*)
Total Sample Size:	25 1 - *Jackson* Class Members 24 - Non-*Jackson* Class Members
Persons Served Records Reviewed:	25
Total Number of *Secondary Freedom of Choices* Reviewed:	Number:104
Case Management Personnel Records Reviewed:	9
Case Manager Personnel Interviewed:	9 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency)*
Administrative Interviews:	1 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency)*

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided

- Accreditation Records
- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - 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
- 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 505-273-1930 or email at MonicaE.Valdez@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, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@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 Monica Valdez, POC Coordinator in any of the following ways:
    a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 87108
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 completion 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 **(*Note: No extensions are granted for the IRF)*.**
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, Valerie V. Valdez at valerie.valdez@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 total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level 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	
Total Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
COP Level Tags:	0 COP	0 COP	0 COP	0 COP	1 to 5 COP	0 to 5 CoPs	6 or more COP
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
"Non-Compliance"						**17 or more** Total Tags with **75 to 100%** of the Individuals in the sample cited in any CoP Level 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** Standard Level Tags, plus **1 to 5** Conditions of Participation Level tags.		
"Partial Compliance with Standard Level tags"			**up to 16** Standard Level Tags with **75 to 100%** of the individuals in the sample cited in any tag.	**17 or more** Standard Level Tags with **50 to 74%** of the individuals in the sample cited any tag.			
"Compliance"	**Up to 16** Standard Level Tags with **0 to 74%** of the individuals in the sample cited in any tag.	**17 or more** Standard Level Tags with **0 to 49%** of the individuals in the sample cited in any tag.					

Agency: **Amigo Case Management Inc. – Metro & Southwest Region**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Case Management
Survey Type: Routine
Survey Date: **June 21 – July 2, 2021**

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Completion Date
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; Re-Issue: 12/28/2018; Eff 1/1/2019 **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.	Based on record review, the Agency did not maintain a complete client record at the administrative office for 5 of 25 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Positive Behavior Support Plan:** • Not Current (#22, 24) **Behavior Crisis Intervention Plan:** • Not Found (#29) **Speech Therapy Plan:** • Not Found (#20) • Not Current (#22) **Occupational Therapy Plan:** • Not Current (#21)	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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. 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	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; Re-Issue: 12/28/2018; Eff 1/1/2019 **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 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.	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 13 of 25 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Annual ISP:** • Not Current (#3) **ISP Assessment Checklist:** • Not Found (#1 & 28) **ISP Signature Page:** • Not Found (#3 & 29) • Not Fully Constituted IDT *(No evidence of DSP involvement)* (#18, 26 & 28) • Not Fully Constituted IDT *(No evidence of Service Coordinator involvement)* (#28) **Addendum A w/ *Incident Mgt. System - Parent/Guardian Training*:** • Not Found (#12) **Individual Specific Training Section (ISP):** • Incomplete (#4) **ISP Teaching & Support Strategies:** ***Individual #3:*** *TSS not found for the following Live Outcome Statement / Action Steps:*	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

6.6 DDSD ISP Template: The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e. an acknowledgement of receipt of specific information) and other elements depending on the age of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use in order to better demonstrate required elements of the PCP process and ISP development. 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.	• "… and DSP will attend desired religious services." *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:* • "… will teach his Direct Support Personnel American Sign Language." • "…will choose signs to help DSP understand his needs/emotions." ***Individual #5:*** *TSS not found for the following Work / Learn Outcome Statement / Action Steps:* • *"…will choose a group activity to participate in."* • *"…will participate in the group activity."* ***Individual #6:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • *"…will work on her daily chores without verbal prompts."* *TSS not found for the following Work / Learn Outcome Statement / Action Steps:* • *"…will complete all job tasks from start to finish until; she receives a raise."* ***Individual #10:*** *TSS not found for the following Work / Learn CCS-I Outcome Statement / Action Steps:* • *"…will choose to participate in community events."* *TSS not found for the following Fun / Relationship CCS-G Outcome Statement / Action Steps:* • *"…will visit a new place of interest."*		

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... **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.	***Individual #18:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "…*will choose a chore to complete around her house."* *TSS not found for the following Fun / Relationship CCS-G Outcome Statement / Action Steps:* • "…*will choose and participate in a physical activity (this may include virtual participation)."* • "…*will choose and participate in a physical activity (this may include virtual participation)."* ***Individual #21:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "…*and staff will research recipe options and assist in creating the ingredient list for shopping."* • "…*will follow the visual recipe to create his smoothie and ENJOY!"* *TSS not found for the following Relationships / Fun Outcome Statement / Action Steps:* • "…*and CCS-I staff will choose some options for activities through research development."* • "…*will create his "vision board" with crafting materials and supplies to post in his room."* ***Individual #27:*** *TSS not found for the following Work / Learn Outcome Statement / Action Steps:* • "…*will help the Route Driver ensure that all headlights, taillights, and turn signals are*		

	working correctly prior to leaving the warehouse at least once a week." ***Individual #28:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "…*will make a choice for lunch or dinner twice a week during the ISP year."* *TSS not found for the following Work / Learn CCS-I Outcome Statement / Action Steps:* • "…*will choose a physical based activity that he would like to participate in twice a week during the ISP year."* **ISP not revised as needed during ISP year** • Individual #3 – Per regulations, ISP (10/8/20 – 10/7/2021) required revision due to CCS-I Services being added to the Budget Worksheet on 4/1/2021. • Individual #21 – Per regulations, ISP (9/1/2020 – 8/31/2021) required revision due to "Adjusted ISP outcomes to fit with current stay at home orders" on 10/7/2020.		

Tag # 1A08.4 Assistive Technology Inventory List	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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 12: Professional and Clinical Services Therapy Services: 12.4.7.3 Assistive Technology (AT) Services, Personal Support Technology (PST) and Environmental Modifications:** Therapists support the person to access and utilize AT, PST and Environmental Modifications through the following requirements: 2. Therapist are required to maintain a current AT Inventory in each Living Supports and CCS site where AT is used, for each person using AT related to that therapist's scope of service. 3. Therapists are required to initiate or update the AT Inventory annually, by the 190th day following the person's ISP effective date, so that it accurately identifies the assistive technology currently in use by the individual and related to that therapist's scope of service. **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.	Based on record review, the Agency did not maintain a complete client record at the administrative office for 1 of 25 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Assistive Technology Inventory List:** • Individual #3 - As indicated by the Health and Safety section of ISP the individual is required to have an inventory list. No evidence of inventory found.	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 4C02 Scope of Services - Primary Freedom of Choice	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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 1:Initial Allocation and Ongoing Eligibility:** Waiver eligibility is determined by the DDSD Intake and Eligibility Bureau (IEB), located statewide in the DDSD Regional Offices. While Provider Agencies are not directly involved in the eligibility determination process, they are an important point of contact. Provider Agencies must refer people to the appropriate DDSD Regional Office where pre-service activities are initiated. ***1.4 Primary Freedom of Choice (PFOC):*** The applicant completes the PFOC form to select between: 1. an Intermediate Care Facility-Intellectual/Developmental Disability) ICF/IID; or 2. the DD Waiver and a Case Management Agency or the Mi Via self-directed waiver and a Consultant Agency. **Chapter 9 Transitions: 9.1 Change in Case Management Agency:** If a person or guardian selects a different case management agency, the following steps must be taken to ensure that critical issues affecting the person's health and safety do not get lost and a complete exchange of information and documentation occurs. 1. The person or guardian has the responsibility to contact his/her local DDSD	Based on record review, the Agency did not maintain documentation assuring individuals obtained all services through the freedom of choice process for 2 of 25 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 (#3, #4)	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Regional Office to complete the PFOC form selecting the new Case Management Agency. 2. When the new Case Management Agency and DDSD receive the PFOC, file transfers must be completed within 30 days. **9.8 Waiver Transfers:** A DD Waiver participant and/or legal representative may choose to transfer to or from another waiver program by contacting the DDSD to initiate a waiver change. If a person wants to switch waivers within the first 30 days of allocation, and no medical or financial eligibility has begun, the transfer is permitted. Waiver transfers are not allowed when the expiration of the person's LOC is within 90 calendar days or less. If the participant has already begun the eligibility or annual recertification process, the person must meet medical and financial eligibility before he/she may request a transfer. Waiver transfers require the following steps: 3. A Waiver Change Form (WCF) is completed by the person and/or legal representative and returned to the local DDSD Regional Office. 4. Once DDSD staff receive the WCF, it is forwarded by DDSD staff to the current DD Waiver CM, Medically Fragile CM, and Mi Via Consultant as relevant. 5. Transfers between waivers should occur within 90 calendar days of receipt of the WCF unless there are circumstances related to the person's services that require more time. 6. Transition meetings must occur within at least 30 days of receipt of the WCF. The receiving agency must schedule the meeting within five days of receipt of the WCF. 7. The transition meeting must occur, either by phone or in person, and is required to include the person or their legal representative, as well as the Mi Via Consultant or Medically Fragile Case Manager and DD Waiver CM who attend in person.			

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 # 4C07 Individual Service Planning *(Visions, measurable outcome, action steps)*	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 4: Person-Centered Planning (PCP): 4.1 Essential Elements of Person-Centered Planning (PCP):** Person-centered planning is a process that places a person at the center of planning his/her life and supports. It is an ongoing process that is the foundation for all aspects of the DD Waiver Program and DD Waiver Provider Agencies' work with people with I/DD. The process is designed to identify the strengths, capacities, preferences, and needs of the person. The process may include other people chosen by the person, who are able to serve as important contributors to the process. Overall, PCP involves person-centered thinking, person-centered service planning, and person-centered practice. PCP enables and assists the person to identify and access a personalized mix of paid and non-paid services and supports to assist him or her to achieve personally defined outcomes in the community. The CMS requires use of PCP in the development of the ISP. **NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS:** Each ISP shall contain. B. Long term vision: The vision statement shall be recorded in the individual's actual words, whenever possible. For example, in a long term vision statement, the individual may describe him or herself living and working independently in the community. C. Outcomes: (1) The IDT has the explicit responsibility of identifying reasonable services and supports	After 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 ensure the ISP was developed in accordance with the rule governing ISP development, as it relates to realistic and measurable desired outcomes and vision statements to 4 of 25 Individuals. The following was found with regards to ISP Outcomes: an **Individual #6:** • "… would like to increase her independence." Outcome does not indicate how and/or when it would be completed. • "… will learn all aspects of her new job position according to her employer's expectations." Outcome does not indicate how and/or when it would be completed. **Individual # 21:** • "… will keep a bowling brag journal of scoring games!" Outcome does not indicate how and/or when it would be completed. **Individual # 22:** • "… wants to communicate her needs and wants in ways that people can understand her." Outcome does not indicate how and/or when it would be completed. • "… would like to explore community activities of her choice." Outcome does not indicate how and/or when it would be completed.	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP. (2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver. D. Individual preference: The individual's preferences, capabilities, strengths and needs in each life area determined to be relevant to the identified ISP outcomes shall be reflected in the ISP. The long term vision, age, circumstances, and interests of the individual, shall determine the life area relevance, if any to the individual's ISP. E. Action plans: (1) Specific ISP action plans that will assist the individual in achieving each identified, desired outcome shall be developed by the IDT and stated in the ISP. The IDT establishes the action plan of the ISP, as well as the criteria for measuring progress on each action step.	• "… would like to maintain a close relationship with her family. …will work on building relationships." Outcome does not indicate how and/or when it would be completed. **Individual # 29:** • "… would like to develop lifelong interest and recreation." Outcome does not indicate how and/or when it would be completed. • "… will work on appropriate social behaviors." Outcome does not indicate how and/or when it would be completed.		

(2) Service providers shall develop specific action plans and strategies (methods and procedures) for implementing each ISP desired outcome. Timelines for meeting each action step are established by the IDT. Responsible parties to oversee appropriate implementation of each action step are determined by the IDT. (3) The action plans, strategies, timelines and criteria for measuring progress, shall be relevant to each desired outcome established by the IDT. The individual's definition of success shall be the primary criterion used in developing objective, quantifiable indicators for measuring progress.			

Tag # 4C07.1 Individual Service Planning – Paid Services	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 4: Person-Centered Planning (PCP): 4.1 Essential Elements of Person-Centered Planning (PCP):** Person-centered planning is a process that places a person at the center of planning his/her life and supports. It is an ongoing process that is the foundation for all aspects of the DD Waiver Program and DD Waiver Provider Agencies' work with people with I/DD. The process is designed to identify the strengths, capacities, preferences, and needs of the person. The process may include other people chosen by the person, who are able to serve as important contributors to the process. Overall, PCP involves person-centered thinking, person-centered service planning, and person-centered practice. PCP enables and assists the person to identify and access a personalized mix of paid and non-paid services and supports to assist him or her to achieve personally defined outcomes in the community. The CMS requires use of PCP in the development of the ISP. **NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS:** Each ISP shall contain…C. Outcomes: (1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the	Based on record review, the Agency did not ensure Case Managers developed outcomes for the individual for each paid service for 1 of 25 Individuals. The following was found with regards to ISP Outcomes: **Individual #3:** • No Outcomes or DDSD exemption/decision justification found for Customized Community Supports – Individual Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver."	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

individual's own words, whenever possible. Outcomes shall be prioritized in the ISP. (2) Outcomes planning shall be implemented in one or more of the four “life areas” (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.			

Tag # 4C07.2 Person Centered Assessment and Career Development Plan	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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;	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 25 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Person Centered Assessment:** • Not Found (#23 & 27) • Not Current (#17)	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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 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 # 4C08 ISP Development Process	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 2: Human Rights:** Civil rights apply to everyone, including all waiver participants, family members, guardians, natural supports, and Provider Agencies. Everyone has a responsibility to make sure those rights are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to best support the person. ***2.2.1 Statement of Rights Acknowledgement Requirements***: The CM is required to review the Statement of Rights (See Appendix C HCBS Consumer Rights and Freedoms) with the person, in a manner that accommodates preferred communication style, at the annual meeting. The person and his/her guardian, if applicable, sign the acknowledgement form at the annual meeting. **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. ***8.2.1 Promoting Self Advocacy and Advocating on Behalf of the Person in Services:*** 10. Reviewing the HCBS Consumer Rights and Freedoms with the person and guardian as applicable, at least annually and in a form/format most understandable by the person. (See Appendix C HCBS Consumer Rights and Freedoms.) 11. Confirming acknowledgement of the	Based on record review, the Agency did not maintain documentation for each person supported according to the following requirements for 5 of 25 individuals. Review of the records indicated the following: **Statement of Rights Acknowledgment:** • Not Found (#10, 12, 24, 26 & 28)	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

HCBS Consumer Rights and Freedoms with signatures of the person and guardian, if applicable.			

Tag # 4C09 Secondary FOC	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 4: Person-Centered Planning (PCP): 4.7 Choice of DD Waiver Provider Agencies and Secondary Freedom of Choice (SFOC):** People receiving DD Waiver funded services have the right to choose any qualified provider of case management services listed on the PFOC and a qualified provider of any other DD Waiver service listed on SFOC form. The PFOC is maintained by each Regional Office. The SFOC is maintained by the Provider Enrollment Unit (PEU) and made available through the SFOC website: http://sfoc.health.state.nm.us/. ***4.7.2. Annual Review of SFOC:*** Choice of Provider Agencies must be continually assured. A person has a right to change Provider Agencies if he/she is not satisfied with services at any time. 1. The SFOC form must be utilized when the person and/or legal guardian wants to change Provider Agencies. 2. The SFOC must be signed at the time of the initial service selection and reviewed annually by the CM and the person and/or guardian. 3. A current list of approved Provider Agencies by county for all DD Waiver services is available through the SFOC website: http://sfoc.health.state.nm.us/ **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.	Based on record review, the Agency did not maintain the Secondary Freedom of Choice documentation (for current services) and/or ensure individuals obtained all services through the Freedom of Choice Process for 17 of 25 individuals. Review of the Agency individual case files revealed 21 out of 104 Secondary Freedom of Choices were not found and/or not agency specific to the individual's current services: **Secondary Freedom of Choice:** • Supported Living (#6, 22 & 26) *(Note: #6 completed during the on-site survey. Provider please complete POC for ongoing QA/QI.)* • Family Living (#10 & 29) • Customized Community Supports (#3, 5, 17, 18, 21, 24 & 26) • Community Integrated Employment Services (#1) • Behavior Consultation (#3, 10, 26 & 29) Speech Therapy (#22, 28 & 29) *(Note: #28 completed during the on-site survey. Provider please complete POC for ongoing QA/QI.)* • Non-Medical Transportation (#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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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 & Evaluation of Services	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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	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 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 5 of 25 individuals. **Review of the Agency individual case files revealed no evidence of Case Manager Monthly Case Notes for the following:** • Individual #8 - None found for 10/2020, 11/2020 and 12/2020. • Individual #10 - None found for 6/2020, 7/2020, 8/2020, 9/2020, 10/2020, 11/2020, 12/2020, 1/2021 and 2/2021. • Individual #26 - None found for 6/2020, 7/2020, 8/2020, 9/2020, 10/2020, 11/2020, 12/2020, 1/2021 and 2/2021. **Review of the Agency individual case files revealed no evidence indicating face-to-face visits were completed as required for the following individuals:** • Individual #8 – No Face to Face Visit Summary Forms found for 10/2020, 11/2020 and 12/2020. • Individual #26 – No Face to Face Visit Summary Forms found for 2/2021, 3/2021, 4/2021 and 5/2021. *(Note: Face to Face Summary forms for these months were in Therap, however, the document was blank).*	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

occur as follows: a. At least one face-to-face visit per quarter shall occur at the person's home for people who receive a Living Supports or CIHS. 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	• Individual #28 – No Face to Face Visit Summary Forms found for 1/2021, 2/2021, 3/2021, 4/2021 and 5/2021. *(Note: Face to Face Summary forms for these months were in Therap, however, the document was blank).* **Review of the Agency individual case files revealed the required Therap Monthly Site Visit Forms were not entered / submitted in Therap as outlined in the Instructions and Guidelines for Case Management Monitoring Activities dated 12/1/2018 pg. 8 #4 *"Save draft or Submit (electronic signature) before the end of the month the visit occurs"* for the following:** **Individual #23** (Non-Jackson) • Face to face visit conducted on 3/17/2021. Monthly Site Visit Form entered / submitted in Therap on 4/2/2021. **Individual #26** (Non-Jackson) • Face to face visit conducted on 7/29/2020. Monthly Site Visit Form entered / submitted in Therap on 8/13/2020.		

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.			

Tag # 4C12.1 Monitoring & Evaluation of Services (IDT Meetings for Significant Life Events)	Standard Level Deficiency		
7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS: H. The IDT shall be convened to discuss and modify the ISP, as needed, to address: (1) a significant life change, including a change in medical condition or medication that affects the individual's behavior or emotional state; (2) situations where an individual is at risk of significant harm. In this case the team shall convene within one working day, in person or by teleconference; if necessary, the ISP shall be modified accordingly within seventy-two (72) hours; (3) changes in any desired outcomes, (e.g. desired outcome is not met, a change in vocational goals or the loss of a job); (4) the loss or death of a significant person to the individual; (5) a serious accident, illness, injury or hospitalization that disrupts implementation of the ISP; (6) individual, guardian or provider requests for a program change or relocation, or when a termination of a service is proposed; the DDSD's policy no. 150 requires the IDT to meet and develop a transition plan whenever an individual is at risk of discharge by the provider agency or anticipates a change of provider agency to identify strategies and resources needed; if the individual or guardian is requesting a discharge or a change of provider agency, or there is an impending change in housemates the team must meet to develop a transition plan; (7) situations where it has been determined the individual is a victim of abuse, neglect or exploitation; (8) criminal justice involvement on the part of the individual (e.g., arrest, incarceration, release, probation, parole);	Based on record review, the Agency did not convene the IDT to discuss and/or modify the ISP and/or address significant changes as required by regulation 2 of 25 individuals. Review of documentation found the following IDT Meeting did not convene as required: **Individual #3** • As indicated by the documentation reviewed, the individual was paired with a new housemate on 10/6/2020. No documented evidence of IDT meeting's taking place were found. • As indicated by the documentation reviewed, the individual was paired with a new housemate on 4/1/2021. No documented evidence of IDT meetings taking place were found. **Individual #6** • As indicated by the documentation reviewed, the individual's new roommate was stealing from the individual and an IDT meeting was scheduled on 10/16/2020. No documented evidence of IDT meetings taking place were found.	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

(9) any member of the IDT may also request that the team be convened by contacting the case manager; the case manager shall convene the team within ten (10) days of receipt of any reasonable request to convene the team, either in person or through teleconference; (10) for any other reason that is in the best interest of the individual, or any other reason deemed appropriate, including development, integration or provision of services that are inconsistent or in conflict with the desired outcomes of the ISP and the long term vision of the individual; (11) whenever the DDSD decides not to approve implementation of an ISP because of cost or because the DDSD believes the ISP fails to satisfy constitutional, regulatory or statutory requirements. **Chapter 6 Individual Service Plan (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. IDT meetings to review and/or modify the ISP must have meeting minutes or a summary documented in the CM record and are required in the following circumstances: 1. When the person or any member of the IDT requests that the team be convened. 2. Within ten days of a person's life change in order to take appropriate actions to minimize a disruption in the person's life. 3. When immediate action is needed after a report of ANE is made or if ANE is substantiated. 4. Within ten days of an ANE Closure letter if issues still need to be addressed. 5. Transition to new provider, program or location is requested. 6. Changes in Desired Outcomes. 7. Loss or death of a significant person.			

8. Within one business day after any identified risk of significant harm, including aspiration risk screened as moderate or high according to the following: a. The meeting may include a teleconference. b. Modifications to the ISP are made within 72 hours. 9. When a person experiences a change in condition including a change in medical condition or medication that affects the person's behavior or emotional state. 10. When a termination of a service is proposed. 11. When there is an impending change in housemates the team must meet to develop a transition plan. 12. When there is criminal justice involvement (e.g., arrest, incarceration, release, probation, parole). 13. Upon notice of an OOHP and need to report and plan for a safe discharge as described in 19.2.1 Out of Home Placement (OOHP) Reporting. 14. Whenever DDSD decides not to approve the implementation of an ISP due to the cost or because DDSD believes the ISP fails to satisfy constitutional, regulatory or statutory requirements. 15. For any other reason that is in the best interest of the person, or deemed appropriate, including development, integration or provision of services that are inconsistent or in conflict with the person's Desired Outcomes of the ISP and the long-term vision.			

Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)	Condition of Participation 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 the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 12 of 25 Individuals: The following was found indicating the agency failed to provide a copy of the ISP within 14 days of the ISP Approval to the Provider Agencies, Individual and / or Guardian: **No Evidence found indicating ISP was distributed:** • Individual #1: ISP was not provided to Provider Agencies, Individual and / or Guardian. • Individual #6: ISP was not provided to Provider Agencies, Individual and / or Guardian. • Individual #8: ISP was not provided to Provider Agencies, Individual and / or Guardian. • Individual #9: ISP was not provided to Individual and / or Guardian. • Individual #10: ISP was not provided to Individual and / or Guardian. • Individual #14: ISP was not provided to individual and / or Guardian.	**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 affect? 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; Re-Issue: 12/28/2018; Eff 1/1/2019 **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.	• Individual #16: ISP was not provided to Provider Agencies, Individual and / or Guardian. • Individual #22: ISP was not provided to Provider Agencies, Individual and / or Guardian. • Individual #26: ISP was not provided to Provider Agencies, Individual and / or Guardian. • Individual #29: ISP was not provided to Provider Agencies, Individual and / or Guardian. **Evidence indicated ISP was provided after 14-day window:** • Individual #5*: ISP approval date was 9/30/2020, ISP was sent to* Provider Agencies, Individual and / or Guardian *on 10/16/2020.* • Individual #23*: ISP approval date was 3/19/2021, ISP was sent to* Provider Agencies, Individual and / or Guardian *on 4/6/2021.*		

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 the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 10 of 25 Individual: The following was found indicating the agency failed to provide a copy of the ISP within 14 days of the ISP Approval to the respective DDSD Regional Office: **No Evidence found indicating ISP was distributed:** • Individual #1 • Individual #6 • Individual #22 • Individual #28 • Individual #29 **Evidence indicated ISP was provided after 14-day window:** • Individual #5*: ISP approval date was 9/30/2020, ISP was sent to DDSD on 10/16/2020.* • Individual #13*: ISP approval date was 7/1/2020, ISP was sent to DDSD on 10/1/2020.* • Individual #16*: ISP approval date was 8/20/2020, ISP was sent to DDSD on 9/8/2020.* • Individual #19*: ISP approval date was 8/14/2020, ISP was sent to DDSD on 5/28/2021.* • Individual #23*: ISP approval date was 3/19/2021, ISP was sent to DDSD on 4/6/2021.*	**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 affect? 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; Re-Issue: 12/28/2018; Eff 1/1/2019 **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	Completion Date
Service Domain: Level of Care – *Initial and annual Level of Care (LOC) evaluations are completed within timeframes specified by the State.*			
Tag # 4C04 Assessment Activities	**Condition of Participation Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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. **8.2.3** ***Facilitating Level of Care (LOC) Determinations and Other Assessment Activities:*** The CM ensures that an initial evaluation for the LOC is complete, and that all participants are reevaluated for a LOC at least annually. CMs are also responsible for completing assessments. related to LOC determinations and for obtaining other assessments to inform the service planning process. The assessment tasks of the CM include, but are not limited to: 1. Completing, compiling, and/or obtaining the elements of the Long-Term Care Assessment Abstract packet to include: a. a Long-Term Care Assessment Abstract form (MAD 378); b. a Client Individual Assessment (CIA); c. a current History and Physical; d. a copy of the Allocation Letter (initial submission only); and e. for children, a norm-referenced assessment. 2. Timely submission of a completed LOC packet for review and approval by the TPA contractor including: a. responding to the TPA contractor within specified timelines when the	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 complete, compile or obtaining the elements of the Long Term Care Assessment Abstract (LTCAA) packet and / or submitted the Level of Care in a timely manner, as required by standard for 6 of 25 individuals. Review of the Agency individual case files indicated the following items were not found, incomplete, and/or not current: **Annual Physical:** • Not Found (#1 & 9) **Client Individual Assessment (CIA):** • Not Found (#4, 6, 9 & 28) • Not Current (#10)	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Long- Term Care Assessment Abstract packet is returned for corrections or additional information; b. submitting complete packets, between 45 and 30 calendar days prior to the LOC expiration date for annual redeterminations; c. seeking assistance from the DDSD Regional Office related to any barriers to timely submission; and d. facilitating re-admission to the DD Waiver for people who have been hospitalized or who have received care in another institutional setting for more than three calendar days (upon the third midnight), which includes collaborating with the MCO Care Coordinator to resolve any problems with coordinating a safe discharge. 3. Obtaining assessments from DD Waiver Provider Agencies within the specified required timelines. 4. Meeting with the person and guardian, prior to the ISP meeting, to review the current assessment information. Leading the DCP as described in Chapter 3.1 Decisions about Health Care or Other Treatment: Decision Consultation and Team Justification Process to determine appropriate action.			

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Completion Date
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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	Based on record review, the Agency did not maintain a complete client record at the administrative office for 4 of 25 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Other Individual Specific Evaluations & Examinations:** **Dental Exam:** • Individual #3 - As indicated by the documentation reviewed, exam was completed on 2/10/2021. Follow-up was to be completed every 3 months. No documented evidence of the follow-up being completed was found. • Individual #8 - As indicated by the DDW Standards Dental Exams are to be conducted annually. No documented evidence of exam was found. • Individual #9 - As indicated by the DDW Standards Dental Exams are to be conducted annually. No documented evidence of exam was found. • Individual #10 - As indicated by the DDW Standards Dental Exams are to be conducted annually. No documented evidence of exam was found.	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; 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 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: 8. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 9. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 11. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 12. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only			

for the services provided by their agency. 13. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 14. 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. **20.5.3 *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.			

Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 22:Quality Improvement Strategy (QIS):** A QIS at the provider level is directly linked to the organization's service delivery approach or underlying provision of services. To achieve a higher level of performance and improve quality, an organization is required to have an efficient and effective QIS. The QIS is required to follow four key principles: 1. quality improvement work in systems and processes; 2. focus on participants; 3. focus on being part of the team; and 4. focus on use of the data. As part of a QIS, Provider Agencies are required to evaluate their performance based on the four key principles outlined above. Provider Agencies are required to identify areas of improvement, issues that impact quality of services, and areas of non-compliance with the DD Waiver Service Standards or any other program requirements. The findings should help inform the agency's QI plan. ***22.2 QI Plan and Key Performance Indicators (KPI):*** Findings from a discovery process should result in a QI plan. The QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving goals, and identifying opportunities for improvement. The QI plan describes the processes that the Provider Agency uses in each phase of the QIS: discovery, remediation, and sustained improvement. It describes the frequency of data collection, the source and types of data	Based on record review the Agency did not maintain a Quality Improvement System (QIS), as required by standards. Review of information found: • Review of the findings identified during the on-site survey (June 21 – July 2, 2021) and as reflected in this report of findings the Agency had multiple deficiencies noted, which indicates the CQI plan provided by the Agency was not being used to successfully to identify and improve systems within the agency.	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

gathered, as well as the methods used to analyze data and measure performance. The QI plan must describe how the data collected will be used to improve the delivery of services and must describe the methods used to evaluate whether implementation of improvements is working. The QI plan shall address, at minimum, three key performance indicators (KPI). The KPI are determined by DOH-DDSQI) on an annual basis or as determined necessary. ***22.3 Implementing a QI Committee:*** A QI committee must convene on at least a quarterly basis and more frequently if needed. The QI Committee convenes to review data; to identify any deficiencies, trends, patterns, or concerns; to remedy deficiencies; and to identify opportunities for QI. QI Committee meetings must be documented and include a review of at least the following: 1. Activities or processes related to discovery, i.e., monitoring and recording the findings; 2. The entities or individuals responsible for conducting the discovery/monitoring process; 3. The types of information used to measure performance; 4. The frequency with which performance is measured; and 5. The activities implemented to improve performance. **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **F. Quality assurance/quality improvement program for community-based service providers:** The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident			

management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program: **(1)** community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(3)** community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.			

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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 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	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 6 of 25 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Electronic Comprehensive Health Assessment Tool:** • Not Found (#3 & 4) ***eCHAT Summary:*** ➢ Not Found (#4,) ➢ Not Current (#10) **Aspiration Risk Screening Tool** (ARST): ➢ Not Current (#10) **Health Care Plans:** ***Body Mass Index*** • Individual #19 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ***Constipation*** • Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Falls*** • Individual #3 - According to Electronic Comprehensive Health Assessment Tool	**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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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. **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: 2. 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,	the individual is required to have a plan. No evidence of a plan found. • Individual #18 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Respiratory*** • Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ***Seizure Disorder*** • Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. **Medical Emergency Response Plans:** ***Aspiration*** • Individual #17 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ***Respiratory*** • Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ***Seizures*** • Individual #3 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.		

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 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: c. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. d. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the			

guardian is interested in considering other options for implementation. 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.			

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Completion Date
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; Re-Issue: 12/28/2018; Eff 1/1/2019 **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:**	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 25 of 25 individuals. *Progress notes and billing records supported billing activities for the months of March, April, and May 2021.*		

For services billed in monthly units, a Provider Agency must adhere to the following: 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.			

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DR. TRACIE C. COLLINS, M.D.
Secretary-Designate

Date: January 11, 2022

To: Andrew Starck, Owner/Director

Provider: Amigo Case Management Inc.
Address: 2610 San Mateo Blvd. NE, Suite B
State/Zip: Albuquerque, New Mexico 87110-3162

E-mail Address: andrew@amigocm.com

Region: Metro and Southwest
Survey Date: Month June 21 – July 2, 2021

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2018:*** Case Management

Survey Type: Routine

Dear Mr. Starck:

The Division of Health Improvement/Quality Management Bureau received notification that as of January 7, 2022, your agency is no longer providing Developmental Disabilities Waiver services for the State of New Mexico. The Plan of Correction process with the Quality Management Bureau was not complete, however due to your provider status:

The Plan of Correction process is now closed.

Thank you for your cooperation and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Monica Valdez, BS

Monica Valdez, BS
Healthcare Surveyor Advanced/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.21.4.DDW.D2729.5.RTN.09.21.011