Date:	December 10, 2021
To:	Kimberly Hawkins, Executive Director / Case Manager
Provider:	Excel Case Management, Inc.
Address:	430 E. Broadway
State/Zip:	Farmington, New Mexico 87401
E-mail Address:	khawkins@excelcasemanagement.com
Region:	Southeast
Survey Date:	November 1 - 12, 2021
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Case Management
Survey Type:	Routine
Team Leader:	Beverly Estrada, ADN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Caitlin Wall, BSW, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Sally Rel, MS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Hawkins;

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

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

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

The following tags are identified as Condition of Participation Level:

- Tag # 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 # 4C07 Individual Service Planning *(Visions, measurable outcome, action steps)*
- Tag # 4C09 Secondary FOC
- Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)
- Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider

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,

Beverly Estrada, ADN

Beverly Estrada, ADN
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	November 1, 2021
Contact:	**Excel Case Management, Inc.** Kimberly Hawkins, Executive Director / Case Manager **DOH/DHI/QMB** Beverly Estrada, ADN, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	November 2, 2021
Present:	**Excel Case Management, Inc.** Kimberly Hawkins, Executive Director / Case Manager **DOH/DHI/QMB** Beverly Estrada, ADN, Team Lead/Healthcare Surveyor Caitlin Wall, BSW, BA, Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor
Exit Conference Date:	November 12, 2021
Present:	**Excel Case Management, Inc.** Kimberly Hawkins, Executive Director / Case Manager Shae Jacobs, Case Manager **DOH/DHI/QMB** Beverly Estrada, ADN, Team Lead/Healthcare Surveyor Caitlin Wall, BSW, BA, Healthcare Surveyor Sally Rel, MS, Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor
Administrative Locations Visited:	0 (*Note: No administrative locations visited due to COVID-19 Public Health Emergency*)
Total Sample Size:	13 0 – *Jackson* Class Members 13 - Non-*Jackson* Class Members
Persons Served Records Reviewed	13
Total Number of *Secondary Freedom of Choices* Reviewed:	Number: 42
Case Management Personnel Records Reviewed	3
Case Manager Personnel Interviewed	2 (*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)

Service Domain: Level of Care - *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: **Excel Case Management, Inc. - Southeast Region**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Case Management
Survey Type: Routine
Survey Date: **November 1 - 12, 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 # 4C07 Individual Service Planning *(Visions, measurable outcome, action steps)*	**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) -**	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 2 of 13 Individuals. **Individual #2:** • Relationships / Fun Outcome: "… will create a play list of his favorite music /movies." Outcome does not indicate how and/or when it would be completed. **Individual #10:** • Live Outcome: "… will master the George Foreman Grill." Outcome does not indicate how and/or when it would be completed. • Relationships / Fun Outcome: "… will walk 5000 steps once a week." 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?)***:** →	

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 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. (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 # 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 3 of 13 individuals. Review of the Agency individual case files revealed 4 out of 42 Secondary Freedom of Choices were not found and/or not agency specific to the individual's current services: **Secondary Freedom of Choice:** • Customized In-Home Supports (#1) • Customized Community Supports (#2) • Community Integrated Employment Services (#1 & 11)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to 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 11 of 13 individuals. **Review of the Agency individual case files revealed no evidence indicating face-to-face visits were completed as required for the following individuals:** • Individual #2 – No Face to Face Visit Summary Forms found for 1/2021. • Individual #5 – No Face to Face Visit Summary Forms found for 5/2021. **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 #1** (Non-Jackson) • Face to face visit conducted on 10/1/2020. Monthly Site Visit Form entered / submitted in Therap on 11/10/2020. • Face to face visit conducted on 11/4/2020. Monthly Site Visit Form entered / submitted in Therap on 12/14/2020.	**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	• Face to face visit conducted on 1/8/2021. Monthly Site Visit Form entered / submitted in Therap on 2/4/2021. • Face to face visit conducted on 2/5/2021. Monthly Site Visit Form entered / submitted in Therap on 3/11/2021. • Face to face visit conducted on 3/3/2021. Monthly Site Visit Form entered / submitted in Therap on 4/6/2021. • Face to face visit conducted on 4/1/2021. Monthly Site Visit Form entered / submitted in Therap on 5/11/2021. • Face to face visit conducted on 5/3/2021. Monthly Site Visit Form entered / submitted in Therap on 6/7/2021. • Face to face visit conducted on 7/7/2021. Monthly Site Visit Form entered / submitted in Therap on 8/2/2021. • Face to face visit conducted on 8/17/2021. Monthly Site Visit Form entered / submitted in Therap on 9/13/2021. • Face to face visit conducted on 9/7/2021. Monthly Site Visit Form entered / submitted in Therap on 10/1/2021. **Individual #3** (Non-Jackson) • Face to face visit conducted on 12/14/2020. Monthly Site Visit Form entered / submitted in Therap on 1/5/2021. • Face to face visit conducted on 1/6/2021. Monthly Site Visit Form entered / submitted in Therap on 2/8/2021.		

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.	• Face to face visit conducted on 2/12/2021. Monthly Site Visit Form entered / submitted in Therap on 3/11/2021. • Face to face visit conducted on 3/8/2021. Monthly Site Visit Form entered / submitted in Therap on 4/6/2021. • Face to face visit conducted on 4/14/2021. Monthly Site Visit Form entered / submitted in Therap on 5/11/2021. • Face to face visit conducted on 5/3/2021. Monthly Site Visit Form entered / submitted in Therap on 6/7/2021. • Face to face visit conducted on 7/8/2021. Monthly Site Visit Form entered / submitted in Therap on 8/2/2021. • Face to face visit conducted on 8/11/2021. Monthly Site Visit Form entered / submitted in Therap on 9/13/2021. • Face to face visit conducted on 9/15/2021. Monthly Site Visit Form entered / submitted in Therap on 10/1/2021. **Individual #4** (Non-Jackson) • Face to face visit conducted on 10/21/2020. Monthly Site Visit Form entered / submitted in Therap on 11/16/2020. • Face to face visit conducted on 11/4/2020. Monthly Site Visit Form entered / submitted in Therap on 12/14/2020. • Face to face visit conducted on 12/3/2020. Monthly Site Visit Form entered / submitted in Therap on 1/6/2021.		

	• Face to face visit conducted on 1/31/2021. Monthly Site Visit Form entered / submitted in Therap on 2/9/2021. • Face to face visit conducted on 3/8/2021. Monthly Site Visit Form entered / submitted in Therap on 4/6/2021. • Face to face visit conducted on 4/13/2021. Monthly Site Visit Form entered / submitted in Therap on 5/13/2021. • Face to face visit conducted on 5/14/2021. Monthly Site Visit Form entered / submitted in Therap on 6/7/2021. • Face to face visit conducted on 7/22/2021. Monthly Site Visit Form entered / submitted in Therap on 8/2/2021. • Face to face visit conducted on 8/11/2021. Monthly Site Visit Form entered / submitted in Therap on 9/13/2021. • Face to face visit conducted on 9/22/2021. Monthly Site Visit Form entered / submitted in Therap on 10/4/2021. **Individual #6** (Non-Jackson) • Face to face visit conducted on 10/23/2020. Monthly Site Visit Form entered / submitted in Therap on 11/5/2020. • Face to face visit conducted on 12/10/2020. Monthly Site Visit Form entered / submitted in Therap on 1/14/2021. • Face to face visit conducted on 3/25/2021. Monthly Site Visit Form entered / submitted in Therap on 4/1/2021.		

	• Face to face visit conducted on 4/15/2021. Monthly Site Visit Form entered / submitted in Therap on 5/10/2021. • Face to face visit conducted on 6/10/2021. Monthly Site Visit Form entered / submitted in Therap on 7/19/2021. • Face to face visit conducted on 7/12/2021. Monthly Site Visit Form entered / submitted in Therap on 8/2/2021. • Face to face visit conducted on 9/22/2021. Monthly Site Visit Form entered / submitted in Therap on 10/4/2021. **Individual #7** (Non-Jackson) • Face to face visit conducted on 10/8/2020. Monthly Site Visit Form entered / submitted in Therap on 11/16/2020. • Face to face visit conducted on 11/25/2020. Monthly Site Visit Form entered / submitted in Therap on 12/28/2020. • Face to face visit conducted on 12/7/2020. Monthly Site Visit Form entered / submitted in Therap on 1/7/2021. • Face to face visit conducted on 1/19/2021. Monthly Site Visit Form entered / submitted in Therap on 2/17/2021. • Face to face visit conducted on 2/8/2021. Monthly Site Visit Form entered / submitted in Therap on 3/12/2021. • Face to face visit conducted on 3/22/2021. Monthly Site Visit Form entered / submitted in Therap on 4/6/2021.		

	• Face to face visit conducted on 4/14/2021. Monthly Site Visit Form entered / submitted in Therap on 5/18/2021. • Face to face visit conducted on 5/21/2021. Monthly Site Visit Form entered / submitted in Therap on 6/8/2021. • Face to face visit conducted on 6/21/2021. Monthly Site Visit Form entered / submitted in Therap on 7/2/2021. • Face to face visit conducted on 7/2/2021. Monthly Site Visit Form entered / submitted in Therap on 8/2/2021. • Face to face visit conducted on 8/24/2021. Monthly Site Visit Form entered / submitted in Therap on 9/14/2021. • Face to face visit conducted on 9/22/2021. Monthly Site Visit Form entered / submitted in Therap on 10/4/2021. **Individual #9** (Non-Jackson) • Face to face visit conducted on 10/12/2020. Monthly Site Visit Form entered / submitted in Therap on 11/5/2020. • Face to face visit conducted on 11/13/2020. Monthly Site Visit Form entered / submitted in Therap on 12/14/2020. • Face to face visit conducted on 12/30/2020. Monthly Site Visit Form entered / submitted in Therap on 1/14/2021. • Face to face visit conducted on 3/17/2021. Monthly Site Visit Form entered / submitted in Therap on 4/1/2021.		

	• Face to face visit conducted on 4/14/2021. Monthly Site Visit Form entered / submitted in Therap on 5/10/2021. • Face to face visit conducted on 5/7/2021. Monthly Site Visit Form entered / submitted in Therap on 6/1/2021. • Face to face visit conducted on 6/17/2021. Monthly Site Visit Form entered / submitted in Therap on 7/19/2021. • Face to face visit conducted on 7/21/2021. Monthly Site Visit Form entered / submitted in Therap on 8/5/2021. • Face to face visit conducted on 9/13/2021. Monthly Site Visit Form entered / submitted in Therap on 10/6/2021. **Individual #10** (Non-Jackson) • Face to face visit conducted on 10/19/2020. Monthly Site Visit Form entered / submitted in Therap on 11/6/2020. • Face to face visit conducted on 11/17/2020. Monthly Site Visit Form entered / submitted in Therap on 12/16/2020. • Face to face visit conducted on 12/10/2020. Monthly Site Visit Form entered / submitted in Therap on 1/14/2021. • Face to face visit conducted on 3/5/2021. Monthly Site Visit Form entered / submitted in Therap on 4/23/2021. • Face to face visit conducted on 4/19/2021. Monthly Site Visit Form entered / submitted in Therap on 5/11/2021.		

	• Face to face visit conducted on 6/18/2021. Monthly Site Visit Form entered / submitted in Therap on 7/19/2021. • Face to face visit conducted on 7/16/2021. Monthly Site Visit Form entered / submitted in Therap on 8/9/2021. • Face to face visit conducted on 9/17/2021. Monthly Site Visit Form entered / submitted in Therap on 10/6/2021. **Individual #12** (Non-Jackson) • Face to face visit conducted on 10/21/2020. Monthly Site Visit Form entered / submitted in Therap on 11/6/2020. • Face to face visit conducted on 11/12/2020. Monthly Site Visit Form entered / submitted in Therap on 12/16/2020. • Face to face visit conducted on 12/14/2020. Monthly Site Visit Form entered / submitted in Therap on 1/14/2021. • Face to face visit conducted on 3/12/2021. Monthly Site Visit Form entered / submitted in Therap on 4/23/2021. • Face to face visit conducted on 4/15/2021. Monthly Site Visit Form entered / submitted in Therap on 5/10/2021. • Face to face visit conducted on 5/6/2021. Monthly Site Visit Form entered / submitted in Therap on 6/1/2021. • Face to face visit conducted on 6/21/2021. Monthly Site Visit Form entered / submitted in Therap on 7/19/2021.		

	• Face to face visit conducted on 7/7/2021. Monthly Site Visit Form entered / submitted in Therap on 8/9/2021. • Face to face visit conducted on 9/13/2021. Monthly Site Visit Form entered / submitted in Therap on 10/6/2021. **Individual #13** (Non-Jackson) • Face to face visit conducted on 10/22/2020. Monthly Site Visit Form entered / submitted in Therap on 11/17/2020. • Face to face visit conducted on 11/19/2020. Monthly Site Visit Form entered / submitted in Therap on 12/28/2020. • Face to face visit conducted on 12/2/2020. Monthly Site Visit Form entered / submitted in Therap on 1/8/2021. • Face to face visit conducted on 1/22/2021. Monthly Site Visit Form entered / submitted in Therap on 2/18/2021. • Face to face visit conducted on 2/3/2021. Monthly Site Visit Form entered / submitted in Therap on 3/23/2021. • Face to face visit conducted on 3/11/2021. Monthly Site Visit Form entered / submitted in Therap on 4/12/2021. • Face to face visit conducted on 4/8/2021. Monthly Site Visit Form entered / submitted in Therap on 5/25/2021. • Face to face visit conducted on 5/18/2021. Monthly Site Visit Form entered / submitted in Therap on 6/10/2021.		

	• Face to face visit conducted on 6/2/2021. Monthly Site Visit Form entered / submitted in Therap on 7/2/2021. • Face to face visit conducted on 7/9/2021. Monthly Site Visit Form entered / submitted in Therap on 8/2/2021. • Face to face visit conducted on 8/3/2021. Monthly Site Visit Form entered / submitted in Therap on 9/13/2021. • Face to face visit conducted on 9/13/2021. Monthly Site Visit Form entered / submitted in Therap on 10/4/2021.		

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 8 of 13 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 Provider Agencies, Individual and / or Guardian: **No Evidence found indicating ISP was distributed:** • Individual #1: ISP was not provided to Individual and Providers Agencies. • Individual #2: ISP was not provided to Guardian and / or Individual. • Individual #4: ISP was not provided to Guardian and / or Individual. • Individual #5: ISP was not provided to Guardian and / or Individual. • Individual #8: ISP was not provided to Guardian and / or Individual. • Individual #11: ISP was not provided to Guardian and / or Individual and LCA / CI providers. • Individual #12: ISP was not provided to Guardian and / or Individual.	**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.	**Evidence indicated ISP was provided after 14-day window:** • Individual #4*: ISP approval date was 4/8/2021, ISP was sent to LCA / CI Providers on 4/27/2021.* • Individual #6*: ISP approval date was 8/6/2021, ISP was sent to Guardian and LCA / CI Providers on 8/24/2021.* • Individual #12*: ISP approval date was 7/14/2021, ISP was sent to LCA / CI Providers on 7/29/2021.*		

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 11 of 13 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 #2 • Individual #4 • Individual #5 • Individual #6 • Individual #8 • Individual #10 • Individual #11 • Individual #12 **Evidence indicated ISP was provided after 14-day window:** • Individual #3*: ISP approval date was 8/10/2021, ISP was sent to DDSD Regional Office on 10/7/2021.* • Individual #7*: ISP approval date was 12/22/2020, ISP was sent to DDSD Regional Office on 5/24/2021.*	**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 3 of 13 individuals. Review of the Agency individual case files indicated the following items were not found, incomplete, and/or not current: **Annual Physical:** • Not Found (#6, 10, 12)	**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 # 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.
	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.
	
	Based on record review, the Agency did not maintain a complete client record at the administrative office for 4 of 13 individuals.
	
	Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:
	
	Aspiration Risk Screening Tool (ARST):
	• Incomplete (#12)
	
	Medical Emergency Response Plans:
	• *Aspiration*
	  • Individual #5 - As indicated by the eCHAT the individual is required to have a plan. No current plan found.
	
	  • Individual #11 - As indicated by the eCHAT the individual is required to have a plan. No current plan found.
	
	• *Bowel and Bladder*
	  • Individual #5 - As indicated by the eCHAT the individual is required to have a plan. No current plan found.
	
	• *Gastrointestinal*
	  • Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan 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?)*: →	

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.
 	
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:
	• *Respiratory / Asthma*
	  • Individual #5 - As indicated by the eCHAT the individual is required to have a plan. No current plan found.
	
	• *Skin Breakdown*
	  • Individual #2 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found.
	
	• *Urinary Retention*
	  • Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. No current plan found.		

1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by 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.			

Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider	Standard Level Deficiency		
NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS: **A. Duty to report:** **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** **(1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse,	Based on record review, the Agency did not report suspected abuse, neglect, or exploitation**,** unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 13 Individuals. During the on-site survey November 1 - 12, 2021, surveyors observed the following: During the on-site visit Surveyor reviewed the August 2021 Case Manager Case Note. The Case Note indicated a Face-to-Face visit took place on 8/18/2021 at 8:30am – 9:30am. CM #502 indicated, "It was concerning that I was the one watching … eat and have to prompt her because staff was on her phone. The meal that was prepared was not healthy or appropriate. We have talked about healthier options and to not have processed food such as frozen burritos served." CM #502 also indicated, "Around 9:10am a new staff for the other roommate arrived and … got up to say hello, I noticed at that time … had stains on her pants in the back. It appeared that maybe … didn't make it to the bathroom quick enough and had an accident in her pants." CM #502 noted she reported the meal supervision to the Provider. As a result of what was observed the following incident was reported by the Provider to DHI: Individual #6 • A State ANE report of neglect was filed on 11/9/2021 by the provider. Incident report was reported to DHI.	**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?)*: →	

neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. **(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form. **(3) Limited provider investigation:** No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation. **(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall:			

(a) develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable; **(b)** be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and **(c)** provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057. **(5) Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident. **(6) Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative. **(7) Case manager or consultant notification by community-based service providers:** The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation			

has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant. **(8) Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation.			

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 13 of 13 individuals. *Progress notes and billing records supported billing activities for the months of July, August and September 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

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

Date: March 1, 2022

To: Kimberly Hawkins, Executive Director / Case Manager

Provider: Excel Case Management, Inc.
Address: 430 E. Broadway
State/Zip: Farmington, New Mexico 87401

E-mail Address: khawkins@excelcasemanagement.com

Region: Southeast
Survey Date: November 1 - 12, 2021

Program Surveyed: Developmental Disabilities Waiver

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

Survey Type: Routine

Dear Ms. Hawkins:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Monica Valdez, BS

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

Q.22.2.DDW.D3826.4.RTN.09.21.060