Date: March 4, 2022

To: Sarah Martinez, Case Manager, Executive Director

Provider: Peak Developmental Services, Inc.
Address: 8501 Candelaria Rd. NE, Building A1
State/Zip: Albuquerque, New Mexico 87112

E-mail Address: smartinez@nmddwcm.com

Region: Metro, Northeast & Northwest
Survey Date: January 24 – February 4, 2022

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Case Management

Survey Type: Routine

Team Leader: Lei Lani Nava, MPH, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Bernadette Baca, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Caitlin Wall, BA, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jamie Pond, QMB Staff Manager, Division of Health Improvement/Quality Management Bureau; Verna Newman-Sikes, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Heather Driscoll, AA Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Wolf Krusemark, BFA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Sarah Martinez;

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

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

Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags: This determination is based on noncompliance with one to five (1 – 5) Condition of Participation Level Tags *(refer to Attachment D for*

details). The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components
- Tag # 4C07 Individual Service Planning *(Visions, measurable outcome, action steps)*
- Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)
- 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 (Other Required Documents)
- Tag # 4C01.1 Case Management Services – Utilization of Services
- Tag # 4C01.4 Case Management Services – Case Manager Advocacy
- 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 Monitoring & Evaluation of Services
- Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)
- Tag # 4C04 Assessment Activities
- Tag # 1A22/4C02 Case Manager: Individual Specific Competencies
- Tag # 1A22.1/4C02.1 Case Manager Competencies: Knowledge of Service
- Tag # 1A28.4 Incident Mg: Case Manager Knowledge of Responsibility of IMB Notification

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,

Lei Lani Nava, MPH

Lei Lani Nava, MPH
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	January 24, 2022
Contact:	**Peak Developmental Services, Inc.** Sarah Martinez, Case Manager, Executive Director **DOH/DHI/QMB** Lei Lani Nava, MPH, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	*Entrance conference was waived by provider*
Exit Conference Date:	February 4, 2022
Present:	**Peak Developmental Services, Inc.** Sarah Martinez, Case Manager, Executive Director **DOH/DHI/QMB** Lei Lani Nava, MPH, Metro, NE, NW Survey Team Lead / Team Lead/Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor Bernadette Baca, MPA, Healthcare Surveyor Heather Driscoll, AA, Healthcare Surveyor Verna Newman-Sikes, AA, Healthcare Surveyor Beverly Estrada, ADN, Southwest Survey Team Lead/Healthcare Surveyor Kayla R. Benally, BSW, Healthcare Surveyor Joshua Burghart, BS, Healthcare Surveyor Lora Norby, Healthcare Surveyor Monica Valdez, BS, Healthcare Surveyor Advanced/Plan of Correction Coordinator **DDSD – Metro, NE, NW, SE Regional Offices** April Armijo, Registered Nurse Magdelyn Montoya, Social Community Service Coordinator Marcia Battle, Case Manger Coordinator Michelle Lyons, SE Regional Director
Administrative Locations Visited:	0 (*Note: No administrative locations visited due to COVID-19 Public Health Emergency*)
Total Sample Size:	57 1 - *Jackson* Class Members 56 - Non-*Jackson* Class Members
Persons Served Records Reviewed	57
Total Number of *Secondary Freedom of Choices* Reviewed:	257
Case Management Personnel Records Reviewed	26
Case Manager Personnel Interviewed	26 *(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: **Peak Developmental Services, Inc. - Metro, Northeast & Northwest Region**
Program: Developmental Disabilities Waiver
Service: Case Management
Survey Type: Routine
Survey Date: **January 24 – February 4, 2022**

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	Based on record review, the Agency did not maintain a complete client record at the administrative office for 5 of 57 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Behavior Crisis Intervention Plan:** • Not Found (#6 & 31) **Speech Therapy Plan:** • Not Found (#45) **Occupational Therapy Plan:** • Not Found (#57) • Not Current (#27)	**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?)*: →	

the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 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	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 12 of 57 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Signature Page:** • Not Fully Constituted IDT *(No evidence of DSP involvement)* (#10, 13 & 27) • Not Fully Constituted IDT *(No evidence of Individual and / or Guardian involvement)* (#11) **ISP Teaching & Support Strategies:** ***Individual #1:*** *TSS not found for the following Work / Learn Outcome Statement / Action Steps:* • "…will learn how to use my tablet with assistance of DSP and SLP to learn apps and find various sites with 1:1 assistance from staff." ***Individual #15:*** *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 #18:*** *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?)*: →	

request to convene the team, either in person or through teleconference. **6.6 DDSD ISP Template:** The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e. an acknowledgement of receipt of specific information) and other elements depending on the age of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning 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.	• "…will work on his garden and worm farm." ***Individual #26:*** *TSS not found for the following Work / Learn Outcome Statement / Action Steps:* • "…will participate in the community activities that he chooses." ***Individual #27:*** *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:* • "…will plan his date with…." • "…will attend his date." ***Individual #31:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "…will coached through her showering routine." • "…will increase her independence for the hygiene routines using a timer, electronic toothbrush and Listerine flossers." ***Individual #35:*** *TSS not found for the following Work / Learn Outcome Statement / Action Steps:* • "While in the community … will take a picture of a street sign." ***Individual #57:*** *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:* • "Create an itinerary of chosen destination and optional side sightseeing."		

5. The CM must review a current Addendum A and DHI ANE letter with the person and Court appointed guardian or parents of a minor, if applicable. **6.7 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.			

Tag # 4C01.1 Case Management Services – Utilization of Services	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: 8.2.7 *Monitoring and Evaluating Service Delivery*** 13. The CM must monitor utilization of budgets by reviewing in the Medicaid Web Portal on a monthly basis in preparation for site visits. The CM uses the information to have informed discussions with the person/guardian about high or low utilization and to follow up with any action that may be needed to assure services are provided as outlined in the ISP with respect to: quantity, frequency and duration. Follow up action may include, but not be limited to: a. documenting extraordinary circumstances; b. convening the IDT to submit a revision to the ISP and budget as necessary; c. working with the provider to align service provision with ISP and using the RORA process if there is no resolution from the provider; and d. reviewing the SFOC process with the person and guardian, if applicable.	Based on record review and interview, the Agency did not have evidence indicating they were monitoring the utilization of budgets for DDW services for 1 of 57 individuals. **Budget Utilization Report:** Individual #23 – *The following was found indicating low or no usage during the term of the ISP budget 5/30/2021 – 5/19/2022, no evidence was found indicating why the usage was low and/or no usage:* • CCS-SG [T2021 HB-U9]: Units approved 1000 units; units used 0 from *5/30/2021 (budget start date)* to *1/22/2022 (utilization report run).* • CCS-I [H2021 HB-U1]: Units approved 1000 units; units used 0 from *5/30/2021 (budget start date)* to *1/22/2022 (utilization report run).*	**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 # 4C01.4 Case Management Services – Case Manager Advocacy	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: 8.1 General Definition and Intent of Case Management Services:** Case Management services are person-centered and intended to support people to pursue their desired life outcomes while gaining independence and access to needed services and supports. The essential elements of Case Management include activities related to advocacy, assessment, planning, linking, and monitoring. DD Waiver CMs also play an important role in allocation, annual medical and financial recertification, record keeping, and budget approvals. CMs must maintain a current and thorough working knowledge of the DD Service Standards and community resources. In addition to paid supports, Case Management services also emphasize and promote the use of natural and generic supports to address a person's assessed needs. **8.2.7 *Monitoring and Evaluating Service Delivery:*** 13. The CM must monitor utilization of budgets by reviewing in the Medicaid Web Portal on a monthly basis in preparation for site visits. The CM uses the information to have informed discussions with the person/guardian about high or low utilization and to follow up with any action that may be needed to assure services are provided as outlined in the ISP with respect to: quantity, frequency and duration. Follow up action may include, but not be limited to: e. documenting extraordinary circumstances; f. convening the IDT to submit a revision to	Based on interview, Case Manager did not participate in the activities related to advocacy, assessment, planning, linking, and monitoring, as required by standards for 1 of 57 individuals. **When the Case Manager was asked what steps are taken when the Individual is not participating in services identified in the budget or is not able to access the services, the following was reported:** Case Manager #503 stated, "I've never had to come across that."	**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?)*: →	

the ISP and budget as necessary; g. working with the provider to align service provision with ISP and using the RORA process if there is no resolution from the provider; and **h.** reviewing the SFOC process with the person and guardian, if applicable.			

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.	Based on record review, the Agency did not maintain documentation assuring individuals obtained all services through the freedom of choice process for 1 of 57 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 (#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?)*: →	

1. The person or guardian has the responsibility to contact his/her local DDSD 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:	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 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 11 of 57 Individuals. The following was found with regards to ISP: **Individual #20** • Vision for Fun, "…wants to learn to use new technology." Outcome indicates, "…will access her community having fun and trying new and different things." Review of ISP found outcome and action step are not related to the vision. **Individual #38** • Vision for Relationship / Fun, "I want to remain physically healthy and strong." Outcome indicates, "I will participate in a scavenger hunt in my home." Review of ISP found outcome and action step are not related to the vision. The following was found with regards to ISP Outcomes: **Individual #11:** • Live Outcome: "Will choose one chore to do a week." Outcome does not indicate how and/or when it would be completed. **Individual #14:**	**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?)*: →	

(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	• Live Outcome: "…will bake foods of her choice." Outcome does not indicate how and/or when it would be completed. • Work / Learn Outcome: "…will participate in CCS-I to access her community." Outcome does not indicate how and/or when it would be completed. **Individual #17:** • Live Outcome: "…will practice her reading, writing, and spelling is to be completed 1 time per week." Outcome does not indicate how and/or when it would be completed. **Individual #18:** • Health Outcome: "…will exercise at least 1 time per month." Outcome does not indicate how and/or when it would be completed. **Individual #20:** • Live Outcome: "…will develop organizational skills, keeping personal areas organized and tidy." Outcome does not indicate how and/or when it would be completed. **Individual #23:** • Live Outcome: "I will use my adaptive music device to participate in a virtual music class." Outcome does not indicate how and/or when it would be completed. • Fun / Develop Relationships Outcome: "I will initiate social interactions with familiar people." Outcome does not indicate how and/or when it would be completed. **Individual #38:** • Live Outcome: "I will enjoy a spa day at home." Outcome does not indicate how and/or when it would be completed.		

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.	• Work /Learn Outcome: "I will use my VOCA to share interests and experiences." Outcome does not indicate how and/or when it would be completed. **Individual #42:** • Live Outcome: "…wants to cook an entrée or side dish 2 times per month." Outcome does not indicate how and/or when it would be completed. • Fun / Develop Relationships Outcome: "…wants to take pictures and put them in a memory book on her iPad or in a scrap book." Outcome does not indicate how and/or when it would be completed. **Individual #51:** • Live Outcome: "…will mail correspondence to her family." Outcome does not indicate how and/or when it would be completed. • Work /Learn Outcome: "…will take an active role in her daily activities." Outcome does not indicate how and/or when it would be completed. • Fun / Develop Relationships Outcome: "…will spend more time with friends out in the community." Outcome does not indicate how and/or when it would be completed. **Individual #55:** • Live Outcome: "I will self-direct my leisure time going to the library – selecting audiobooks that I can enjoy is to be completed 2 times per month." Outcome does not indicate how and/or when it would be completed.		

	Individual #56: • Live Outcome: "…will remain living with her family while working on her beading and crafting with beads." Outcome does not indicate how and/or when it would be completed.		

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	Based on record review, the Agency did not ensure Case Managers developed outcomes for the individual for each paid service for 1 of 57 Individuals. The following was found with regards to ISP Outcomes: **Individual #40:** • No Outcomes or DDSD exemption/decision justification found for CCS-G 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?)*: →	

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.			

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	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 57 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Person Centered Assessment:** • Not Current (#3)	**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?)*: →	

background and status; b. the person's strengths and interests; c. conditions for success to integrate into the community, including conditions for job success (for those who are working or wish to work); and 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.)	Based on record review, the Agency did not maintain documentation for each person supported according to the following requirements for 10 of 57 individuals. Review of the records indicated the following: **Statement of Rights Acknowledgment:** • Not Found (#12, 18, 22, 24, 30, 35, 43, 50 & 57) • Not Current (#45)	**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?)*: →	

11. Confirming acknowledgement of the 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:	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 13 of 57 individuals. Review of the Agency individual case files revealed 20 out of 257 Secondary Freedom of Choices were not found and/or not agency specific to the individual's current services: **Secondary Freedom of Choice:** • Supported Living (#3, 6, 20) • Family Living (#22) • Customized Community Supports (#26, 51, 57) • Behavior Consultation (#3, 6, 30, 47) • Speech Therapy (#22) • Physical Therapy (#27) • Occupational Therapy (#21, 51) • Adult Nursing Services (#6, 12) • Socialization and Sexuality (#27) • Non-Medical Transportation (#12) • Fiscal Management Adult Education (#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?)*: →	

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.			

Tag # 4C12 Monitoring & Evaluation of Services	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. ***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	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 7 of 57 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 #56 (Non-Jackson) – No Face-to-Face Visit Summary Forms found for March - June 2021. **Review of the Agency individual case files revealed face-to-face visits were not being completed as required by standard (#2, #5 a, b, c) for the following individuals:** **Individual #38** (Jackson) • No home visit was noted in 03/2021. **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 #20** (Non-Jackson)	**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?)*: →	

(including JCMs) living in the community. 5. For non-JCMs, face-to-face visits must occur as follows: a. At least one face-to-face visit per quarter shall 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	• Face to face visit conducted on 8/25/2021. Monthly Site Visit Form entered / submitted in Therap on 9/1/2021. **Individual #22** (Non-Jackson) • Face to face visit conducted on 8/12/2021. Monthly Site Visit Form entered / submitted in Therap on 9/1/2021. • Face to face visit conducted on 8/25/2021. Monthly Site Visit Form entered / submitted in Therap on 9/1/2021. **Individual #31** (Non-Jackson) • Face to face visit conducted on 6/14/2021. Monthly Site Visit Form entered / submitted in Therap on 2/2/2022. **Individual #38** (Jackson) • Face to face visit conducted on 1/19/2021. Monthly Site Visit Form entered / submitted in Therap on 2/8/2021. • Face to face visit conducted on 2/25/2021. Monthly Site Visit Form entered / submitted in Therap on 3/2/2021. • Face to face visit conducted on 4/16/2021. Monthly Site Visit Form entered / submitted in Therap on 5/13/2021. • Face to face visit conducted on 5/21/2021. Monthly Site Visit Form entered / submitted in Therap on 6/1/2021. • Face to face visit conducted on 6/16/2021. Monthly Site Visit Form entered / submitted in Therap on 7/5/2021.		

required by New Mexico Statutes and complete all follow up activities as detailed in Chapter 18: Incident Management System. 9. If concerns regarding the health or safety of the person are documented during monitoring or assessment activities, the CM immediately notifies appropriate supervisory personnel within the DD Waiver Provider Agency and documents the concern. In situations where the concern is not urgent, the DD Waiver Provider Agency is allowed up to 15 business days to remediate or develop an acceptable plan of remediation. 10. If the CMs reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed upon period of time, the CM shall use the RORA process detailed in Chapter 19: Provider Reporting Requirements. 11. The CM conducts an online review in the Therap system to ensure that the e-CHAT and *Health Passport* are current: quarterly and after each hospitalization or major health event. 14. The CM will ensure Living Supports, CIHS, CCS, and CIE are delivered in accordance with CMS Setting Requirements described in Chapter 2.1 CMS Final Rule: Home and Community-Based Services (HCBS) Settings Requirements. If additional support is needed, the CM notifies the DDSD Regional Office through the RORA process.	• Face to face visit conducted on 7/12/2021. Monthly Site Visit Form entered / submitted in Therap on 8/4/2021. • Face to face visit conducted on 7/23/2021. Monthly Site Visit Form entered / submitted in Therap on 8/1/2021. • Face to face visit conducted on 8/13/2021. Monthly Site Visit Form entered / submitted in Therap on 9/7/2021. • Face to face visit conducted on 9/17/2021. Monthly Site Visit Form entered / submitted in Therap on 11/2/2021. • Face to face visit conducted on 10/19/2021. Monthly Site Visit Form entered / submitted in Therap on 11/2/2021. • Face to face visit conducted on 11/19/2021. Monthly Site Visit Form entered / submitted in Therap on 12/2/2021. **Individual #46** (Non-Jackson) • Face to face visit conducted on 8/1/2021. Monthly Site Visit Form entered / submitted in Therap on 9/1/2021. • Face to face visit conducted on 5/29/2021. Monthly Site Visit Form entered / submitted in Therap on 1/5/2022. **Individual #55** (Non-Jackson) • Face to face visit conducted on 8/10/2021. Monthly Site Visit Form entered / submitted in Therap on 9/1/2021.		

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	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on record review and/or interview the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 23 of 57 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 #3: ISP was not provided to the Provider Agencies, Individual and / or Guardian. • Individual #5: ISP was not provided to the Provider Agencies, Individual and / or Guardian. • Individual #6: ISP was not provided to Individual and / or Guardian. • Individual #7: ISP was not provided to Individual and / or Guardian. • Individual #11: ISP was not provided to Individual and / or Guardian. • Individual #12: 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?)*: →	

IDT members, not only those affected by the revisions. 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 #13: ISP was not provided to the Provider Agencies. • Individual #15: ISP was not provided to the Provider Agencies, Individual and / or Guardian. • Individual #16: ISP was not provided to the CI Provider Agency. • Individual #34: ISP was not provided to the Provider Agencies. • Individual #35: ISP was not provided to the Individual and / or Guardian. • Individual #39: ISP was not provided to the Provider Agencies, Individual and / or Guardian. • Individual #40: ISP was not provided to the Provider Agencies, Individual and / or Guardian. • Individual #44: ISP was not provided to the Provider Agencies. • Individual #56: ISP was not provided to the Provider Agencies, Individual and / or Guardian. **Evidence indicated ISP was provided after 14-day window:** • Individual #2*: ISP approval date was 5/10/2021, ISP was sent to Provider Agencies, Individual and / or Guardian on 5/27/2021.* • Individual #13*: ISP approval date was 6/8/2021, ISP was sent to Individual and / or Guardian on 6/25/2021.*		

	• Individual #16*: ISP approval date was 8/10/2021, ISP was sent to LCA Provider Agencies, Individual and / or Guardian on 8/27/2021.* • Individual #18*: ISP approval date was 6/1/2021, ISP was sent to Provider Agencies, Individual and / or Guardian on 9/13/2021.* • Individual #24*: ISP approval date was 11/10/2021, ISP was sent to Provider Agencies, Individual and / or Guardian on 11/29/2021.* • Individual #27*: ISP approval date was 4/20/2021, ISP was sent to Provider Agencies, Individual and / or Guardian on 6/14/2021.* • Individual #35*: ISP approval date was 10/20/2021, ISP was sent to Provider Agencies on 2/2/2022.* • Individual #42*: ISP approval date was 8/12/2021, ISP was sent to Provider Agencies, Individual and / or Guardian on 10/5/2021.* • Individual #44*: ISP approval date was 7/7/2021, ISP was sent to Individual and / or Guardian on 7/26/2021.* • Individual #47*: ISP approval date was 11/22/2021, ISP was sent to Provider Agencies on 12/15/2021 and to Individual and / or Guardian on 12/16/2021.* • Individual #51*: ISP approval date was 7/28/2021, ISP was sent to Provider*		

	Agencies, Individual and / or Guardian on 8/27/2021. • Individual #52*: ISP approval date was 5/4/2021, ISP was sent to Provider Agencies, Individual and / or Guardian on 5/27/2021.*		

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 and/or interview the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 26 of 57 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 #3 • Individual #6 • Individual #15 • Individual #40 • Individual #56 **Evidence indicated ISP was provided after 14-day window:** • Individual #2*: ISP approval date was 5/10/2021, ISP was sent to DDSD on 5/27/2021.* • Individual #7*: ISP approval date was 6/1/2021, ISP was sent to DDSD on 7/1//2021.* • Individual #12*: ISP approval date was 11/3/2021, ISP was sent to DDSD on 12/10/2021.*	**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.	• Individual #13*: ISP approval date was 6/8/2021, ISP was sent to DDSD on 6/24/2021.* • Individual #16*: ISP approval date was 8/10/2021, ISP was sent to DDSD on 8/27/2021.* • Individual #18*: ISP approval date was 6/1/2021, ISP was sent to DDSD, on 10/7/2021.* • Individual #21*: ISP approval date was 11/18/2021, ISP was sent to DDSD on 1/3/2022.* • Individual #22*: ISP approval date was 5/21/2021, ISP was sent to DDSD on 12/28/2021.* • Individual #24*: ISP approval date was 11/10/2021, ISP was sent to DDSD on 11/29/2021.* • Individual #27*: ISP approval date was 4/20/2021, ISP was sent to DDSD on 6/14/2021.* • Individual #35*: ISP approval date was 10/20/2021, ISP was sent to DDSD on 11/23/2021.* • Individual #39*: ISP approval date was 2/12/2021, ISP was sent to DDSD on 4/30/2021.* • Individual #42*: ISP approval date was 8/12/2021, ISP was sent to DDSD on 11/5/2021.*		

	• Individual #43*: ISP approval date was 7/27/2021, ISP was sent to DDSD on 12/6/2021.* • Individual #44*: ISP approval date was 7/7/2021, ISP was sent to DDSD, on 7/26/2021.* • Individual #45*: ISP approval date was 10/27/2021, ISP was sent to DDSD, on 12/16/2021.* • Individual #47*: ISP approval date was 11/22/2021, ISP was sent to DDSD, on 12/15/2021.* • Individual #49*: ISP approval date was 9/10/2021, ISP was sent to DDSD, on 1/24/2022.* • Individual #50*: ISP approval date was 3/26/2021, ISP was sent to DDSD, on 5/3/2021.* • Individual #51*: ISP approval date was 7/28/2021, ISP was sent to DDSD on 8/27/2021.* • Individual #52*: ISP approval date was 5/4/2021, ISP was sent to DDSD on 5/27/2021.*		

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	**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. **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	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 4 of 57 individuals. Review of the Agency individual case files indicated the following items were not found, incomplete, and/or not current: **Annual Physical:** • Not Found (#12, 54) **Client Individual Assessment (CIA):** • Not Found (#33) • Not Current (#6, 54)	**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?)*: →	

within specified timelines when the 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: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A22 / 4C02 Case Manager: Individual Specific Competencies	**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 Scope:** DD Waiver CMs must have knowledge of the requirements for the entire system to effectively provide and monitor services. In general, the CM's scope of practice is to: 1. promote self-advocacy and advocate on behalf of the person; 2. facilitate and monitor the allocation and annual recertification processes as well as transitions as described in Chapter 9: Transitions; 3. participate in specific assessment activities related to annual LOC determination and PCP; 4. link the person and guardian to publicly funded programs, community resources and non-disability specific resources available to all citizens and natural supports within the person's community; 5. organize and facilitate the PCP process and ISP development in accordance with the DD Waiver Service Standards as described in Chapter 4: Person-Centered Planning and Chapter 6: Individual Service Plan (ISP); 6. submit the ISP and the Waiver Budget Worksheet (BWS) or MAD 046 and any other required documents to TPA Contractor(s), as outlined in Chapter 7: Available Services and Individual Budget Development; 7. monitor the ISP implementation including service delivery, coordination of other supports, and health and safety assurances as	Based on interview, the Agency did not ensure each case manager met the IST requirements in accordance with the specifications described in the ISP of each person supported for 3 of 26 Case Managers. **When the Case Managers were asked, if the Individual had Assistive Technology or Adaptive Equipment, the following was reported:** • #503 stated, "Glasses and cell phone." According to the Individual Specific Training Section of the ISP and agency file, the individual additionally uses a cane, wheelchair and walker. (Individual #42) **When the Case Managers were asked, if the Individual had Therapies and if they knew why they are needed, the following was reported:** • #503 stated, "She has physical therapy, OT therapy and speech therapy." According to the Individual Specific Training Section of the ISP, the Individual additionally requires a Behavioral Therapy Plan). (Individual #42) • #520 stated, "Nope." According to the Individual Specific Training Section of the ISP, the individual requires a CARMP and a MERP for Constipation. (Individual #15) • #524 stated, "She does have a HCP for her BMI, she is overweight. She used to have a	**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?)*: →	

described in the ISP; and 8. maintain a complete record for each person in services, as specified in Chapter 20: Provider Documentation and Client Records and Appendix A Client File Matrix. **8.2.1 *Promoting Self Advocacy and Advocating on Behalf of the Person in Services:*** A primary role of the CM is to facilitate self-advocacy and advocate on behalf of the person, which includes, but is not limited to: 1 Operating under the Employment First Principle and facilitating employment decisions based on informed choice…. 2 Monitoring to determine if reasonable accommodations are made including assistive technology. 3 Using PCP which aids people to advocate for themselves, as needed and when appropriate. 4 Notifying the DDSD Regional Office, through the RORA process, if supports are unavailable. 5 Documenting through ISP meeting minutes, contact notes, or DDSD issued forms and templates that decisions made by the person and/or the guardian are based on the completion of required elements of informed choice as outlined in Chapter 4.5 Informed Choice. 6 Educating other healthcare and DD Waiver Provider Agencies in recognizing and respecting the needs, strengths, and goals of the person. 7 Facilitating IDT meetings in a manner that promotes conflict free service and support coordination as described in Chapter 4.8 Conflict-Free Service and Support Coordination. 8 Ensuring that a discussion on	HCP for hygiene but it has been discontinued." According to the Individual Specific Training Section of the ISP, the individual additionally requires plans for Allergies (Individual #14)		

individualized Meaningful Day activities occurs in the ISP meeting and is reflected in the ISP. 9 Ensuring that a discussions of non-disability specific options and actions to increase self- determination occurs in the planning process, before development of the annual budget, and is documented in IDT meeting minutes, contact notes, or relevant DDSD Issued forms and templates. 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 HCBS Consumer Rights and Freedoms with signatures of the person and guardian, if applicable. 12 Reviewing the ISP Addendum A at least annually to discuss: Individual Client Rights, Client Complaint Procedure, the Dispute Resolution Process, and ANE reporting, with the person and guardian as applicable and in a form/format most understandable by the person. 13 Confirming acknowledgement of the receipt Addendum A with signatures of the person and guardian, if applicable. 14 Discussing and providing information regarding hospice services, palliative care, and end of life care, when appropriate. 15 Leading the SFOC process as described in Chapter 4.7.2 Annual Review of SFOC including specific responsibilities to… ***8.3.1 CM Qualifications and Training Requirements: 1.*** Within specified timelines, Case Management Provider Agencies must assure that all CMs meet the requirements for			

pre-service and core competency training as specified in the Chapter 17: Training Requirements.			

Tag # 1A22.1 / 4C02.1 Case Manager Competencies: Knowledge of Service	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 Scope:** DD Waiver CMs must have knowledge of the requirements for the entire system to effectively provide and monitor services. In general, the CM's scope of practice is to: 1. promote self-advocacy and advocate on behalf of the person; 2. facilitate and monitor the allocation and annual recertification processes as well as transitions as described in Chapter 9: Transitions; 3. participate in specific assessment activities related to annual LOC determination and PCP; 4. link the person and guardian to publicly funded programs, community resources and non-disability specific resources available to all citizens and natural supports within the person's community; 5. organize and facilitate the PCP process and ISP development in accordance with the DD Waiver Service Standards as described in Chapter 4: Person-Centered Planning and Chapter 6: Individual Service Plan (ISP); 6. submit the ISP and the Waiver Budget Worksheet (BWS) or MAD 046 and any other required documents to TPA Contractor(s), as outlined in Chapter 7: Available Services and Individual Budget Development; 7. monitor the ISP implementation including service delivery, coordination of other supports, and health and safety assurances as described in the ISP; and	Based on interview, the Agency did not ensure the case manager had the knowledge of the requirements for the entire system to effectively provide and monitor services as indicated in the Scope of Case Management Services for 1 of 26 Case Managers. **When the Case Manager was asked what are the steps of the Employment 1st Principle and how do they ensure this occurs, the following was reported:** • #503 stated, "What I've been doing is contacting the individual and family. They have been telling me that they're not comfortable if I come around. I just obey what they want and need. First, I have them fill out an SFOC to see where they want to work at. Then I send it to the agency they want to start working at and set up a meet and greet. Then I revise the budget and let the individual and agency know when the budget is approved." **When the Case Managers were asked, what steps do you take when the provider agency does not resolve the issue or does not provide you with the needed documents (i.e., appointment results, etc.), the following was reported:** • #503 stated, "Keep bugging them until I get it and letting them know that I need to submit the budget and if I don't have it, we will have to revise the budget once I get the paperwork." **When the Case Manager was asked what State Agency do you report to if you**	**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?)*: →	

8. maintain a complete record for each person in services, as specified in Chapter 20: Provider Documentation and Client Records and Appendix A Client File Matrix. **8.2.1 *Promoting Self Advocacy and Advocating on Behalf of the Person in Services:*** A primary role of the CM is to facilitate self-advocacy and advocate on behalf of the person, which includes, but is not limited to: 1 Operating under the Employment First Principle and facilitating employment decisions based on informed choice…. 2 Monitoring to determine if reasonable accommodations are made including assistive technology. 3 Using PCP which aids people to advocate for themselves, as needed and when appropriate. 4 Notifying the DDSD Regional Office, through the RORA process, if supports are unavailable. 5 Documenting through ISP meeting minutes, contact notes, or DDSD issued forms and templates that decisions made by the person and/or the guardian are based on the completion of required elements of informed choice as outlined in Chapter 4.5 Informed Choice. 6 Educating other healthcare and DD Waiver Provider Agencies in recognizing and respecting the needs, strengths, and goals of the person. 7 Facilitating IDT meetings in a manner that promotes conflict free service and support coordination as described in	**suspect Abuse, Neglect or Exploitation, the following was reported:** • #503 stated, "Department of Health Clinical Service Bureau." The case manager was not able to identify the State Agency as Division of Health Improvement. **When the Case Manager was asked to give examples of Abuse, Neglect and Exploitation, the following was reported:** • #503 stated, "Abuse is when the individual may have bruises on them. Neglect is not taking care of them. I really wouldn't know what to tell you for exploitation, I really don't know the answer for that."		

Chapter 4.8 Conflict-Free Service and Support Coordination. 8 Ensuring that a discussion on individualized Meaningful Day activities occurs in the ISP meeting and is reflected in the ISP. 9 Ensuring that a discussions of non-disability specific options and actions to increase self- determination occurs in the planning process, before development of the annual budget, and is documented in IDT meeting minutes, contact notes, or relevant DDSD Issued forms and templates. 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 HCBS Consumer Rights and Freedoms with signatures of the person and guardian, if applicable. 12 Reviewing the ISP Addendum A at least annually to discuss: Individual Client Rights, Client Complaint Procedure, the Dispute Resolution Process, and ANE reporting, with the person and guardian as applicable and in a form/format most understandable by the person. 13 Confirming acknowledgement of the receipt Addendum A with signatures of the person and guardian, if applicable. 14 Discussing and providing information regarding hospice services, palliative care, and end of life care, when			

appropriate. 15 Leading the SFOC process as described in Chapter 4.7.2 Annual Review of SFOC including specific responsibilities to… ***8.3.1 CM Qualifications and Training Requirements:*** 1. Within specified timelines, Case Management Provider Agencies must assure that all CMs meet the requirements for pre-service and core competency training as specified in the Chapter 17: Training Requirements. **Chapter 17 Training Requirements: 17.2 Training Requirements for CMs and Case Management Supervisors** 1. CMs must successfully: a. complete IST requirements in accordance with the specifications described in the ISP of each person supported; b. complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14; c. complete training regarding the HIPAA; and d. complete the ARM course offered by the DDSD. 2. CM and CM Supervisors shall also complete DDSD-approved core curriculum training facilitated by certified trainers and mentors			

Tag # 1A28.4 Incident Mg: Case Manager Knowledge Case Manager Knowledge of Responsibility of IMB Notification	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 18: Incident Management System:** An Incident Management System (IMS) is a critical part of an agency's practice to ensure swift and appropriate response to any allegations or substantiated findings related to abuse, neglect, and exploitation (ANE), suspicious injury, environmental hazard, or death. All DD Waiver Provider Agencies shall establish and maintain an IMS, which emphasizes the principles of prevention and staff involvement. A comprehensive IMS for DD Waiver Provider Agencies involves training, monitoring, cooperation with DOH-DHI, reporting and continuous risk management activities. **18.8 Case Management and DD Waiver Provider Agency Responsibilities for Risk Management**: DD Waiver Provider Agencies have a continuous responsibility to monitor for risk of harm especially during and after an investigation. Responsibilities including the following requirements: 1. After an ANE report is made, if any member of the IDT, receives information or observes that the IASP is not being followed during the investigation, the person shall report the information to the DHI hotline at 1-800-445-6242. Further information can be found at https://nmhealth.org/about/dhi/ane/racp/. 2. In situations where DHI substantiates the ANE report, the CM must: a. Convene the DD Waiver participant's IDT to review the DHI findings detailed in the DHI issued *Decision Letter:*	Based on interview, the Agency did not ensure case managers followed incident management procedures as required by standards for 1 of 26 case managers. **When Case Managers were asked what steps they are required to follow if there is a substantiated allegation of ANE for an Individual they serve, the following was reported**: • #503 stated, "Get a meeting together to find out what we need to do to get the Health Department involved and find out what we need to do to resolve the issue. I document the meeting minutes and send them to the DDW." When the Case Manager was asked, "How long do you have to send the IDT meeting minutes to IMB?" They responded, "I'm not sure. I haven't had to do this yet." Per standards the CM must submit the IDT meeting minutes with a signature page to DHI within 10 business days of receiving the DHI IMB letter.	**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?)*: →	

Substantiated; b. Modify the person's ISP, if necessary, to address any concerns identified in the investigation; and c. Submit the IDT meeting minutes with a signature page to DHI within 10 business days of receiving the DHI IMB letter. i. The IDT meeting minutes must address all the concerns identified in the IMB closure letter. ii. If the IDT already met and addressed all the concerns identified in the letter, there is no need to hold another meeting. If the IDT meeting did not address all concerns identified, then the CM may need to hold another IDT meeting. 3. At any time, in situations where a person is at significant risk of harm, the CM must convene the IDT within one working day, in person or by teleconference, and modify the ISP, if necessary, within 72-hours.			

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
	Based on record review, the Agency did not maintain a complete client record at the administrative office for 16 of 57 individuals.
	
	Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:
	
	eCHAT Summary:
	➢ Not Current (#6)
	
	Comprehensive Aspiration Risk Management Plan (CARMP):
	➢ Not Found (#12, 57)
	
	Health Care Plans:
	• *Body Mass Index*
	  • Individual #11 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. No evidence of plan found.
	
	  • Individual #18 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. No evidence of plan found.
	
	• *Falls*
	  • Individual #36 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. No evidence of plan found
	
	  • Individual #46 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. 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?)*: →	

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:
1. The DCP is used when a person or
	• *Hygiene / Self-care*
	  • Individual #27 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found.
	
	• *Risk for Fractures & Falls*
	  • Individual #55 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. No evidence of plan found
	
	• *Skin / Wound*
	  • Individual #55 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. No evidence of plan found
	
	• *Vagal Nerve Stimulator*
	  • Individual #3 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found.
	
	• *Vitamin B Deficiency*
	  • Individual #55 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. No evidence of plan found
	
	• *Vitamin D Deficiency*
	  • Individual #46 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. No evidence of plan found
	
	Medical Emergency Response Plans:
	• *A1C Levels*
	  • Individual #3 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found.
	
	• *Allergies*		

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	• Individual #13 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • Individual #23 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • *Body Mass Index* • Individual #45 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • *Endocrine* • Individual #3 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found. • *Falls* • Individual #36 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • Individual #46 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • *Gastrointestinal* • Individual #30 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • *High Risk of Fractures* • Individual #46 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found. • *Neurology* • Individual #3 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found.		

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.
	• *Risk for Fractures & Falls*
	  • Individual #55 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found.
	• *Seizures*
	  • Individual #3 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found.
	  • Individual #21 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found.
	  • Individual #36 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found.
	• *Skin / Wound*
	  • Individual #55 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found.
	Other Individualized Plans:
	Nutritional Plan:
	• Individual #5 - As indicated by collateral documentation reviewed, the individual is required to have a plan. No evidence of plan found.
	• Individual #3 - As indicated by collateral documentation reviewed, the individual is required to have a plan. No evidence of plan found.		

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 57 of 57 individuals. *Progress notes and billing records supported billing activities for the months of October, November, and December 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: June 9, 2022

To: Sarah Martinez, Case Manager, Executive Director

Provider: Peak Developmental Services, Inc.
Address: 8501 Candelaria Rd. NE, Building A1
State/Zip: Albuquerque, New Mexico 87112

E-mail Address: smartinez@nmddwcm.com

Region: Metro, Northeast & Northwest
Survey Date: January 24 – February 4, 2022

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Case Management

Survey Type: Routine

Dear Ms. Martinez:

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.22.3.DDW.D2793.1/2/5.RTN.09.22.160