NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date:	November 15, 2023
To:	Sarah Herrington, Case Management Director / Case Manager
Provider:	J & J Home Care, Inc.
Address:	105 West 3rd St.
State/Zip:	Roswell, New Mexico 88201
E-mail Address:	sarahp@jjhc.org
Region:	Southeast
Routine Survey:	April 10 – 21, 2023
Verification Survey:	October 10 – 18, 2023
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Case Management
Survey Type:	Verification
Team Leader:	Heather Driscoll, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Marie Passaglia, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Sarah Herrington,

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on April 10 – 21, 2023*.

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

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

The following tags are identified as Condition of Participation Level:

- Tag # 4C12 Monitoring & Evaluation of Services ***(New / Repeat Findings)***
- Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian) ***(New / Repeat Findings)***

The following tags are identified as Standard Level:

- Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components ***(New / Repeat Findings)***
- Tag # 4C09 Secondary FOC ***(New / Repeat Findings)***
- Tag # 4C15.1 Service Monitoring: Annual / Semi-Annual Reports & Provider Semi – Annual / Quarterly Report ***(New / Repeat Findings)***
- Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office) ***(New / Repeat Findings)***
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans) ***(New / Repeat Findings)***

However, due to the new/repeat deficiencies your agency will be required to contact your DDSD Regional Office for technical assistance and follow up and complete the Plan of Correction document attached at the end of this report. Please respond to the Plan of Correction Coordinator within 10 business days of receipt of this letter.

Plan of Correction:
The attached Report of Findings identifies the new/repeat Standard Level deficiencies found during your agency's verification compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 10 business days from the receipt of this letter. The Plan of Correction must include the following:

1. Evidence your agency has contacted your DDSD Regional Office for technical assistance.
2. A Plan of Correction detailing Quality Assurance/Quality Improvement processes to prevent your agency from receiving deficiencies in the future. Please use the format provided at the end of this report.
3. Documentation verifying that newly cited deficiencies have been corrected.

Submission of your Plan of Correction:
Please submit your agency's Plan of Correction and documentation verifying correction of survey deficiencies within 10 business days of receipt of this letter to the parties below:

1. **Quality Management Bureau, Attention: Plan of Correction Coordinator**
   5300 Homestead Rd. NE, Suite 300, New Mexico 87110
   MonicaE.Valdez@doh.nm.gov

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

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

Please call the Plan of Correction Coordinator Monica Valdez at 505-273-1930 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,

Heather Driscoll, AA

Heather Driscoll, AA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	October 10, 2023
Contact:	**J & J Home Care, Inc.** Sarah Herrington, Case Management Director / Case Manager **DOH/DHI/QMB** Heather Driscoll, AA, Team Lead/Healthcare Surveyor
Entrance Conference Date:	(*Note: Entrance meeting was waived by provider)*
Exit Conference Date:	October 18, 2023
Present:	**J & J Home Care, Inc.** Sarah Herrington, Case Management Director / Case Manager **DOH/DHI/QMB** Heather Driscoll, AA, Team Lead/Healthcare Surveyor Sally Karingada, BS, Healthcare Surveyor Supervisor Marie Passaglia, BA, Healthcare Surveyor **DDSD - SE Regional Office** Cindy Hoefs, Social & Community Services Coordinator
Administrative Locations Visited:	0 *(Administrative portion of survey completed remotely)*
Total Sample Size:	52 7 – *Former Jackson* Class Members 45 - Non-*Jackson* Class Members
Persons Served Records Reviewed	52
Total Number of *Secondary Freedom of Choices* Reviewed during Routine survey:	207
Total Number of *Secondary Freedom of Choices* Reviewed during Verification survey:	96
Case Management Personnel Records Reviewed	15
Case Manager Personnel Interviewed during routine survey	12
Administrative Interview completed during Routine survey	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - 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

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@doh.nm.gov. 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 ensure 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 corrections 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@doh.nm.gov 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 via email at MonicaE.valdez@doh.nm.gov. Please also submit your POC to your Developmental Disabilities Supports Division Regional Office for region of service surveyed.
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. You must also submit evidence of the ongoing Quality Assurance/Quality Improvement processes.

1. Your internal documents are due within a *maximum* of 45-business days of receipt of your Report of Findings.
2. Please submit your documents electronically according to the following: If documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to the State email account. If documents contain PHI **do not** submit PHI directly to the State email account. *You may submit PHI **only** when **replying** to a **secure** email received from the State email account*. When possible, please submit requested documentation using a "zipped/compressed" file to reduce file size. You may also submit documents via S-Comm (Therap), or another electronic format, i.e., flash drive.
3. All submitted documents *must be annotated*; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

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

Attachment B

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

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

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

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

Conditions of Participation (CoPs)

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

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

<u>Service Domain: Plan of Care ISP Development & Monitoring -</u> *Service plans address all participants' 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 –** Approval Budget Worksheet Waiver Review Form / MAD 046
- **4C12 –** Monitoring & Evaluation of Services
- **4C16 –** Requirements for Reports & Distribution of ISP (Provider Agencies, Individual and/or Guardian)

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

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

- **4C04 –** Assessment Activities

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

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

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

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

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

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

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

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

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

- **1A05 –** General Requirements

Attachment C

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

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

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be received in writing by the QMB 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@doh.nm.gov 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 of 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: **J & J Home Care, Inc. - Southeast Region**
Program: Developmental Disabilities Waiver
Service: Case Management
Survey Type: Verification
Routine Survey: **April 10 – 21, 2023**
Verification Survey: **October 10 – 18, 2023**

Standard of Care	Routine Survey Deficiencies April 10 – 21, 2023	Verification Survey New and Repeat Deficiencies October 10 – 18, 2023
Service Domain: Plan of Care - ISP Development & Monitoring – *Service plans address all participants' 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 # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components	**Condition of Participation Level Deficiency**	**Standard 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 Waiver Service Standards Eff 11/1/2021 **Chapter 6 Individual Service Plan (ISP): 6.2 IDT Membership and Meeting Participation** **The Interdisciplinary Team (IDT) membership and meeting participation varies per person.** 1. At least the following IDT participants are required to contribute: a. the person receiving services and supports; b. court appointed guardian or parents of a minor, if applicable; c. CM; d. friends requested by the person; e. family member(s) and/or significant others requested by the person;	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 38 of 57 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Annual ISP:** • Not Found (#22) **Addendum A w/ *Incident Mgt. System - Parent/Guardian Training*:** • Not Found (#3, 9, 12, 16, 18, 19, 20, 22, 27, 30, 35, 36, 37, 38, 41, 42, 45, 47, 48, 53, 54, 57) **ISP Signature Page:** • Not Found (#3, 12, 16, 18, 19, 20, 22, 27, 35, 36, 37, 38, 41, 42, 45, 47, 53, 54, 57) • Not Fully Constituted IDT *(No evidence of LCA Service Coordinator involvement)* (#21)	**New/Repeat Findings:** Based on record review, the Agency did not maintain a complete client record at the administrative office for 2 of 52 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **ISP Assessment Checklist:** • Not Found (#21, 57)

f. DSP who provide the on-going, regular support to the person in the home, work, and/or recreational activities; g. Provider Agency service coordinators; and h. ancillary providers such as the OT, PT, SLP, BSC, nurse and nutritionist, as appropriate; and i. healthcare coordinator… 3. IDT member participation can occur in person/face-to-face or remotely. Remote/video participation must align with Federal Guidelines for HIPPA Privacy. All confidential protected health information (HIPAA Sensitive PHI) must be sent through SComm in Therap by Provider Agencies required to have SComm accounts. 4. If a required participant is not able to attend the meeting in person or remotely, their input should be obtained by the CM prior to that meeting. Within 5 business days following the meeting, the CM needs to follow-up with that participant and document accordingly. **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 requirement: 1. CMs will provide complete copies of the ISP to the Provider Agencies listed in the budget, the person and the guardian, if applicable, at least 14 calendar days prior to the start of the new ISP. Copies shall include any related ISP minutes, TSS, IST Attachment A, Addendum A, signature page and revisions, if applicable. 2. CMs will provide complete copies of the ISP to the respective DDSD Regional Offices 14 calendar days prior to the start of the new ISP. 3. The case file must contain the documents identified in Appendix A: Client File Matrix. 4. All pages of the documents must include the person's name and the date the document was prepared.	• Not Fully Constituted IDT *(No evidence of LCA / CI DSP involvement)* (#21, 28) • Not Fully Constituted IDT *(No evidence of Community Integrated Employment Services DSP involvement)* (#32) **ISP Teaching & Support Strategies:** ***Individual #1:*** *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:* • "…will research event." • "…will choice event." ***Individual #2:*** *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:* • "…will order his item." • "…will pay for his item." ***Individual #4:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "…will choose a friend." • "…will choose the activity." • "…will attend activity." *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:* • "…will choose the walk trail." • "…will go for her walk." ***Individual #5:*** *TSS not found for the following Fun / Relationship Outcome Statement / Action Steps:* • "…will fill out deposit slip."	

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 are acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all 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.	***Individual #40:*** *TSS not met for the following Fun / Relationship Outcome Statement / Action Steps:* • "…will reach." • "…will plan at least." ***Individual #48:*** *TSS not met for the following Live Outcome Statement / Action Steps:* • "Choose what I want to cook." • "Prepare the meal." *TSS not met for the following Work / Learn Outcome Statement / Action Steps:* • "…will identify and assist in checking the 5 fluids required for van maintenance." *TSS not met for the following Fun / Relationship Outcome Statement / Action Steps:* • "Price the shirts and save money for purchase." • "Buy the t-shirt." ***Individual #56:*** *TSS not met for the following Live Outcome Statement / Action Steps:* • "…will develop a book of meal preferences." **ISP Assessment Checklist:** • Not Found (#3, 6, 15, 21, 22, 24, 33, 35, 36, 37, 38, 41, 42, 43, 44, 47, 52, 53, 54, 57) • Not Current (#12, 18, 19, 32)	

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.		

Tag # 4C09 Secondary FOC	Standard Level Deficiency	Standard Level Deficiency
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **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 requirement: 3. The case file must contain the documents identified in Appendix A: Client File Matrix. **Chapter 4 Person Centered Planning (PCP): 4.4 Freedom of Choice of DD Waiver Provider Agencies:** People receiving DD Waiver funded services have the right to choose any qualified provider of case management services listed on the PFOC (Primary Freedom of Choice) or CM Agency Change Form and a qualified provider of any other DD Waiver service listed on SFOC (Secondary Freedom of Choice) form. 4.4.2 **Annual Review of SFOC:** Choice of Provider Agencies must be continually assured. A person has a right to change Provider Agencies if they are 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. **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	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 28 of 57 individuals. Review of the Agency individual case files revealed 41 out of 207 Secondary Freedom of Choices were not found and/or not agency specific to the individual's current services: **Secondary Freedom of Choice:** • Supported Living (#6, 16, 48) • Family Living (#19, 22, 53, 54) • Intensive Medical Living Services (#46) • Customized In Home Services (#36) • Customized Community Supports (#6, 19, 20, 35, 38, 45, 48, 53, 57) • Community Integrated Employment Services: (#18, 36, 48) • Behavior Consultation (#4, 9, 16, 20, 45, 48) • Speech Therapy (#1, 2, 6, 16, 23, 28, 29, 33, 45, 49, 53) • Adult Nursing Services (#5) • Assistive Technology Purchasing Agent (#11) • Socialization and Sexuality (#39)	**New/Repeat Findings:** 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 5 of 28 individuals. Review of the Agency individual case files revealed 7 out of 96 Secondary Freedom of Choices were not found and/or not agency specific to the individual's current services: **Secondary Freedom of Choice:** • Supported Living (#16, 48) • Customized Community Supports (#6, 16) • Behavior Consultation (#48) • Speech Therapy (#11, 49) Per the Agency's Plan of Correction approved on 8/15/2023, "…file reviews will be completed to ensure ongoing compliance with obtaining a complete individual file. …follow up of missing documents will be monitored each month until documents are obtained and put in the file." Evidence of file reviews was provided during the Verification Survey completed October 10 - 18, 2023. However, QA/ QI was not completed to ensure a complete file for (#6, 11, 16, 18, 48, 49).

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: 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.		

Tag # 4C12 Monitoring & Evaluation of Services	Condition of Participation Level Deficiency	Condition of Participation Level Deficiency
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **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 requirement: 3. The case file must contain the documents identified in Appendix A: Client File Matrix. **8.2.7 Monitoring and Evaluating Service Delivery:** The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health and safety of the person. Monitoring and evaluation activities include the following requirements: 1. The CM is required to meet face-to-face with adult DD Waiver participants at least 12 times annually (one time per month) to bill for a monthly unit. 2. JCMs require two face-to-face contacts per month to bill the monthly unit, one of which must occur at a location in which the person spends the majority of the day (i.e., place of employment, habilitation program), and the other contact must occur at the person's residence. 3. Parents of children on the DD Waiver must receive a minimum of four visits per year, as established in the ISP. The parent is responsible for monitoring and evaluating services provided in the months case management services are not received. 4. No more than one IDT Meeting per quarter may count as a face-to-face contact for adults (including JCMs) living in the community. 5. For non-JCMs, face-to-face visits must occur as follows:	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 support provided to the individual for 41 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 #2 – No Face-to-Face Therap ® Monthly Site Visit Forms found for December 2022 and January 2023. • Individual #3 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October and December 2022, January – March 2023. • Individual #6 – No Face-to-Face Therap ® Monthly Site Visit Forms found for June, October and December 2022, January – March 2023. • Individual #11 – No Face-to-Face Therap ® Monthly Site Visit Forms found for August 2022. • Individual #12 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022 – March 2023. • Individual #14 – No Face-to-Face Therap ® Monthly Site Visit Forms found for May, June, August, September, and November 2022. • Individual #15 – No Face-to-Face Therap ® Monthly Site Visit Forms found for August, November, and December 2022.	**New/Repeat Findings:** 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 support provided to the individual for 21 of 52 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 #43 – No Face-to-Face Therap ® Monthly Site Visit Forms found for August 2023. • Individual #47 – No Face-to-Face Therap ® Monthly Site Visit Forms found for July 2023. **Review of the Therap ® Monthly Site Visit Form revealed face-to-face visits were not being completed as required by standard (#2, #5 a, b, c) for the following individuals:** **Individual #1** (Former Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 6/8/2023 – 2:30 PM – 3:00 PM. • 6/26/2023 – 11:45 AM – 12:15 PM. • 9/8/2023 – 11:00 AM – 11:30 AM.

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 the 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 all applicable current HCPs (including applicable CARMP), MERPs, Health Passport, PBSP or other applicable behavioral plans (such as PPMP or RMP), and WDSIs are in place in the applicable service sites. b. The content of each plan is to be reviewed for accuracy and discrepancies. c. 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. MERP's are determined by the e-chat and the BCIPs are determined by the critical behavioral needs as assessed by the BSC in collaboration with the IDT. d. a printed copy of Current Health Passport is required to be at all service delivery sites. 7. When risk of significant harm is identified, the CM follows. the standards outlined in Section II Chapter 18: Incident Management System.	• Individual #18 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October and December 2022, January 2023. • Individual #19 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022, January, and February 2023. • Individual #20 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022 – March 2023. • Individual #24 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022 – March 2023. • Individual #25 – No Face-to-Face Therap ® Monthly Site Visit Forms found for December 2022. • Individual #27 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022, January – March 2023. • Individual #30 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022 – March 2023. • Individual #32 – No Face-to-Face Therap ® Monthly Site Visit Forms found for April and October 2022, January – March 2023. • Individual #33 – No Face-to-Face Therap ® Monthly Site Visit Forms found for August 2022. • Individual #36 – No Face-to-Face Therap ® Monthly Site Visit Forms found for February and March 2023.	• 9/21/2023 – 10:00 AM – 10:30 AM. **Individual #2** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 5/5/2023 – 1:15 PM – 2:15 PM. • 8/29/2023 – 9:00 AM – 9:30 AM. • 9/29/2023 – 1:00 PM – 1:15 PM. **Individual #3** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 7/31/2023 – 9:30 AM – 10:00 AM. • 9/8/2023 – 10:00 AM – 10:30 AM. **Individual #6** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 5/9/2023 – 1:30 PM – 2:00 PM. **Individual #8** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note

8. The CM must report all suspected ANE as required by New Mexico Statutes and complete all follow up activities as detailed in Section II Chapter 18: Incident Management System. 9. If there are concerns regarding the health or safety of the person 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 Section II 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. 12. The CM must monitor utilization of budgets by reviewing in the Medicaid Web Portal monthly 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.	• Individual #38 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022 – March 2023. • Individual #41 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022 – March 2023. • Individual #42 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022, January – March 2023. • Individual #43 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022, January – March 2023. • Individual #45 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022, January – March 2023. • Individual #47 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022, January – March 2023. • Individual #48 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022 – March 2023. • Individual #51 – No Face-to-Face Therap ® Monthly Site Visit Forms found for January and February 2023 *(2 visits)*, March 2023 *(1 visit)*. • Individual #52 – No Face-to-Face Therap ® Monthly Site Visit Forms found for August 2022. • Individual #53 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022, January – March 2023. • Individual #54 – No Face-to-Face Therap ® Monthly Site Visit Forms found for April – July 2022, September 2022 – March 2023.	template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 7/19/2023 – 1:40 PM – 2:00 PM. • 8/31/2023 – 9:00 AM – 9:15 AM. **Individual #11** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 5/11/2023 – 11:50 AM – 12:15 PM. • 6/14/2023 – 2:55 PM – 3:35 PM. **Individual #14** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 7/11/2023 – 10:45 AM – 11:15 AM. **Individual #15** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 5/3/2023 – 3:00 PM – 4:00 PM. • 8/21/2023 – 12:00 PM – 12:30 PM.

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…If additional support is needed, the CM notifies the DDSD Regional Office through the RORA process. 15. Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap by the last day of the month in which the visit was completed.	• Individual #56 – No Face-to-Face Therap ® Monthly Site Visit Forms found for January and February 2023 *(2 visits each month), and March 2023 (1 visit)*. • Individual #57 – No Face-to-Face Therap ® Monthly Site Visit Forms found for October 2022, January – March 2023. **Review of the Therap ® Monthly Site Visit Form revealed face-to-face visits were not being completed as required by standard (#2, #5 a, b, c) for the following individuals:** **Individual #1** (Former Jackson) Per standards JCMs require two face-to-face contacts per month to bill the monthly unit. No second visit was found for February 2023. **Individual #2** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 5/17/2022 – 10:30 AM – 11:00 AM. **Individual #3** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/14/2022 – 10:00 AM – 10:30 AM. • 5/31/2022 – 11:00 AM – 11:30 AM.	**Individual #25** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 6/27/2023 – 2:15 PM – 2:45 PM. • 9/27/2023 – 11:30 AM – 11:45 AM. **Individual #27** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 6/29/2023 – 2:00 PM – 2:30 PM. **Individual #30** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 6/21/2023 – 10:45 AM – 11:15 AM. **Individual #31** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 8/1/2023 – 1:30 PM – 1:45 PM.

	• 6/27/2022 – 10:00 AM – 10:30 AM. • 7/7/2022 – 10:00 AM – 10:30 AM. • 8/24/2022 – 9:30 AM – 10:00 AM. • 9/9/2022 – 10:30 AM – 11:00 AM. **Individual #6** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 5/17/2022 – 1:00 PM – 1:30 PM. • 7/28/2022 – 11:00 AM – 11:30 AM. • 8/18/2022 – 10:30 AM – 11:00 AM. • 9/13/2022 – 11:00 AM – 11:30 AM. • 11/17/2022 – 11:00 AM 11:30 AM. **Individual #8** (Non-Jackson) No home visits were noted between August 2022 – February 2023. • 8/23/2022 – 11:00 AM – 11:30 AM – Site visit. • 9/29/2022 – 10:15 AM – 10:45 AM – Site visit. • 10/20/2022 – 10:15 AM – 10:45 AM – Site visit. • 11/15/2022 – 10:30 AM – 11:00 AM – Site visit. • 12/1/2022 – 10:00 AM – 10:30 AM – Site visit. • 1/5/2023 – 12:00 PM - 1:00 PM – Site visit. • 2/23/2023 – 1:30 PM – 2:00 PM – Site visit.	• 9/5/2023 – 1:00 PM – 1:15 PM. **Individual #35** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 9/15/2023 – 12:00 PM – 12:30 PM. **Individual #38** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 9/12/2023 – 12:30 PM – 1:15 PM. **Individual #41** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 6/15/2023 – 1:00 PM – 1:30 PM. **Individual #42** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 6/23/2023 – 9:30 AM – 10:00 AM

	Individual #12 (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/27/2022 – 10:00 AM – 10:30 AM. • 5/26/2022 – 9:00 AM – 9:30 AM. • 6/8/2022 – 1:00 PM – 1:30 PM. • 7/13/2022 – 1:00 PM – 1:30 PM. • 8/17/2022 – 9:00 AM – 9:30 AM. • 9/14/2022 – 10:00 AM – 10:30 AM. **Individual #18** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/20/2022 – 11:00 AM – 11:30 AM. • 5/17/2022 – 10:00 AM – 10:30 AM. • 6/21/2022 – 11:00 AM – 12:00 PM. • 7/26/2022 – 12:00 PM – 12:30 PM. • 8/31/2022 – 3:00 PM – 3:30 PM. • 9/28/2022 – 11:00 AM – 11:30 AM. • 11/15/2022 – 11:00 AM – 11:30 AM.	**Individual #43** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 7/31/2023 – 12:00 PM – 12:30 PM. **Individual #45** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 7/31/2023 – 10:30 AM – 11 AM. **Individual #54** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 9/12/2023 – 1:30 PM – 2:30 PM. **Individual #56** (Former Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 6/22/2023 – 10:00 AM – 10:30 AM. Per the Agency's Plan of Correction approved on 8/15/2023, "CM office assistant then reviews each

	• 12/1/2022 – 12:00 PM – 12:30 PM. • 2/14/2023 – 12:30 PM – 1:45 PM. **Individual #19** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/12/2022 – 10:00 AM – 10:30 AM. • 5/5/2022 – 1:00 PM – 1:30 PM. • 6/23/2022 – 10:00 AM – 10:30 AM. • 7/28/2022 – 4:00 PM – 4:40 PM. • 8/18/2022 – 10:00 AM – 10:30 AM. • 9/16/2022 – 1:00 PM – 1:30 PM. • 11/11/2022 – 3:00 PM – 4:00 PM. • 12/28/2022 – 1:00 PM – 1:30 PM. • 3/30/2023 – 12:45 PM – 1:15 PM. **Individual #20** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/27/2022 – 11:30 AM – 12:00 PM. • 5/26/2022 – 2:00 PM – 2:30 PM.	visit in depth to ensure that monitoring questions are being answered…" Evidence of visit reviews was provided during the Verification Survey completed October 10 - 18, 2023. However, Face to Face notes were not completed as required for (#1, 2, 3, 6, 8, 11, 14, 15, 25, 27, 30, 31, 35, 38, 41, 42, 43, 45, 54, 56)

	• 6/30/2022 – 2:00 PM – 2:30 PM. • 7/27/2022 – 1:00 PM – 1:30 PM. • 8/17/2022 – 1:30 PM – 2:30 PM. • 9/14/2022 – 3:00 PM – 4:00 PM. **Individual #24** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/27/2022 – 11:00 AM – 11:30 AM. • 5/26/2022 – 2:00 PM – 2:30 PM. • 6/30/2022 – 2:00 PM – 2:30 PM. • 7/27/2022 – 1:00 PM – 1:30 PM. • 8/17/2022 – 10:30 AM – 11:00 AM. • 9/14/2022 – 1:00 PM – 1:30 PM. **Individual #27** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/14/2022 – 10:30 AM – 11:00 AM. • 5/11/2022 – 9:00 AM – 10:00 AM. • 6/26/2022 – 10:00 AM – 10:30 AM.	

	• 7/8/2022 – 12:30 PM – 1:00 PM. • 8/24/2022 – 11:30 AM – 12:00 PM. • 9/10/2022 – 9:00 AM – 9:30 AM. • 11/3/2022 – 4:00 PM – 4:30 PM. • 12/2/2022 – 1:00 PM – 1:30 PM. **Individual #30** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/27/2022 – 11:30 AM – 12:00 PM. • 5/26/2022 – 11:30 AM – 12:00 PM. • 6/8/2022 – 1:30 PM – 2:00 PM. • 7/13/2022 – 12:30 PM – 1:00 PM. • 8/17/2022 – 10:00 AM – 10:30 AM. • 9/14/2022 – 1:30 PM – 2:00 PM. **Individual #31** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 5/17/2022 – 3:30 PM – 4:00 PM. **Individual #32** (Non-Jackson)	

	Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 5/24/2022 – 2:00 PM – 2:30 PM. • 6/2/2022 – 2:00 PM – 2:30 PM. • 7/12/2022 – 2:00 PM – 2:30 PM. • 8/16/2022 – 1:00 PM – 2 PM. • 9/30/2022 – 2:00 PM – 2:30 PM. • 11/17/2022 – 2:00 PM – 2:30 PM. • 12/29/2022 – 2:00 PM – 2:30 PM. **Individual #35** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/14/2022 – 8:30 AM – 9:00 AM. • 5/31/2022 – 9:30 AM – 10:00 AM. • 6/25/2022 – 1:00 PM – 1:30 PM. **Individual #36** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date,	

	time and location of visit, however required monitoring questions were blank for: • 4/27/2022 – 11:00 AM – 11:30 AM. **Individual #38** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/27/2022 – 11:00 AM – 11:30 AM. • 5/26/2022 – 2:00 PM – 2:30 PM.. • 6/30/2022 – 2:00 PM – 2:30 PM. • 7/27/2022 – 1:00 PM – 1:30 PM. • 8/17/2022 – 11:00 AM – 11:30 AM. • 9/14/2022 – 1:00 PM – 1:30 PM. **Individual #41** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/27/2022 – 11:00 AM – 11:30 AM. • 5/26/2022 – 2:00 PM – 2:30 PM. • 6/30/2022 – 2:00 PM – 2:30 PM. • 7/27/2022 – 2:00 PM – 3:00 PM. • 8/17/2022 – 10:30 AM – 11:00 AM.	

	• 9/14/2022 – 1:00 PM – 1:30 PM. **Individual #42** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/28/2022 – 10:00 AM – 10:30 AM. • 5/31/2022 – 10:00 AM – 10:30 AM. • 6/27/2022 – 10:30 AM- 11:00 AM. • 7/8/2022 – 10:30 AM- 11:00 AM. • 8/24/2022 – 10:30 AM- 11:00 AM. • 9/9/2022 – 10:00 AM – 10:30 AM. • 11/29/2022 – 10:00 AM – 11:00 AM. • 12/2/2022 – 10:00 AM – 10:30 AM. **Individual #43** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/28/2022 – 9:00 AM – 10:00 AM. • 5/31/2022 – 10:30 AM- 11:00 AM. • 6/27/2022 – 10:30 AM- 11:00 AM. • 7/8/2022 – 10:00 AM – 10:30 AM.	

	• 8/24/2022 – 11:00 AM – 11:30 AM. • 9/9/2022 – 10:00 AM – 10:30 AM. • 11/29/2022 – 11:00 AM – 11:30 AM. • 12/2/2022 – 10:30 AM- 11:00 AM. **Individual #45** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/12/2022 – 4:00 PM – 4:30 PM. • 5/31/2022 – 10:00 AM – 10:30 AM. • 6/25/2022 – 1:30 PM – 2:00 PM. • 7/9/2022 – 10:00 AM – 10:30 AM. • 8/24/2022 – 2:00 PM – 2:30 PM. • 11/4/2022 – 11:30 AM – 12:00 PM. • 12/3/2022 – 6:00 PM – 6:30 PM. **Individual #47** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/29/2022 – 11:00 AM – 11:30 AM. • 5/30/2022 – 10:00 AM – 10:30 AM.	

	• 6/25/2022 – 12:30 PM – 1:00 PM. • 7/9/2022 – 12:00 PM – 1:00 PM. • 8/23/2022 – 11:30 AM – 12:00 PM. • 11/4/2022 – 11:00 AM – 11:30 AM. • 12/3/2022 – 12:00 PM – 12:30 PM. **Individual #48** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/27/2022 – 10:00 AM – 10:30 AM. • 5/26/2022 – 9:30 AM – 10:00 AM. • 6/8/2022 – 1:00 PM – 1:30 PM. • 7/13/2022 – 1:00 PM – 1:30 PM. • 8/17/2022 – 9:30 AM – 10:00 AM. • 9/14/2022 – 10:00 AM – 10:30 AM. **Individual #50** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 6/30/2022 – 9:30 AM – 10:00 AM. **Individual #51** (Former Jackson)	

	Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 9/1/2022 – 2:00 PM – 2:30 PM. • 9/19/2022 – 9:00 AM – 9:30 AM. • 10/11/2022 – 10:30 AM – 11:00 AM. • 10/31/2022 – 1:00 PM – 1:30 PM. • 11/15/2022 – 9:00 AM – 9:30 AM. • 11/28/2022 – 10:00 AM – 10:30 AM. • 12/1/2022 – 11:30 AM – 12:00 PM. • 12/21/2022 – 10:30 AM – 11:00 AM. **Individual #53** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/14/2022 – 8:30 AM – 9:00 AM. • 5/31/2022 – 11:30 AM – 12:00 PM. • 6/26/2022 – 10:00 AM – 10:30 AM. • 7/7/2022 – 11:00 AM – 11:30 AM. • 8/23/2022 – 1:00 PM – 1:30 PM. • 9/9/2022 – 11:00 AM – 11:30 AM.	

	• 11/3/2022 – 11:00 AM – 11:30 AM. • 12/3/2022 – 6:00 PM – 6:30 PM. **Individual #56** *(Former Jackson)* Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 12/1/2022 – 11:00 AM – 11:30 AM. • 12/14/2022 – 11:00 AM – 11:30 AM. **Individual #57** (Non-Jackson) Per standards Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap. Review of document found the Monthly Face-to-Face visit Form contained date, time and location of visit, however required monitoring questions were blank for: • 4/29/2022 – 10:30 AM – 11:00 AM. • 5/31/2022 – 1:00 PM – 1:30 PM. • 6/25/2022 – 11:00 AM – 11:30 AM. • 7/8/2022 – 11:00 AM – 11:30 AM. • 8/24/2022 – 1:00 PM – 1:30 PM. • 9/10/2022 – 10:00 AM – 10:30 AM. • 11/3/2022 – 1:00 PM – 1:30 PM. • 12/2/2022 – 1:00 PM – 1:30 PM.	

	Review of the Agency individual case files revealed no evidence of Case Manager Monthly Contact Case Notes for the following: • Individual #1 - None found for 6/2022, 9/2022, 11/2022, and 12/2022. • Individual #3 – None found for 4/2022 – 3/2023. • Individual #4 – None found for 5/2022 6/2022, 8/2022, 10/2022 – 1/2023, and 3/2023. • Individual #5 – None found for 4/2022 – 7/2022 and 9/2022 – 12/2022. • Individual #6 – None found for 4/2022 – 3/2023. • Individual #9 – None found for 2/2023 and 3/2023. • Individual #12 – None found for 4/2022 – 3/2023. • Individual #15 – None found for 5/2022, 6/2022, 8/2022, 9/2022, and 11/2022. • Individual #16 – None found for 4/2022. • Individual #18 – None found for 4/2022 – 12/2022, and 3/2023. • Individual #19 – None found for 4/2022 – 3/2023. • Individual #20 – None found for 4/2022 – 3/2023. • Individual #21 – None found for 8/2022, 10/2022, 11/2022, and 1/2023. • Individual #24 – None found for 4/2022 – 3/2023. • Individual #25 – None found for 12/2022. • Individual #27 – None found for 4/2022 – 3/2023.	

	• Individual #30 – None found for 4/2022 – 3/2023. • Individual #32 – None found for 4/2022 – 3/2023. • Individual #33 – None found for 4/2022 – 3/2023. • Individual #34 – None found for 5/2022. • Individual #35 – None found for 4/2022 – 3/2023. • Individual #36 – None found for 4/2022 – 3/2023. • Individual #38 – None found for 4/2022 – 3/2023. • Individual #41 – None found for 4/2022 – 3/2023. • Individual #42 – None found for 4/2022 – 3/2023. • Individual #43 – None found for 4/2022 – 3/2023. • Individual #45 – None found for 4/2022 – 3/2023. • Individual #47 – None found for 4/2022 – 3/2023. • Individual #48 – None found for 4/2022 – 3/2023. • Individual #50 – None found for 4/2022 – 3/2023. • Individual #51 – None found for 4/2022 – 3/2023. • Individual #52 – None found for 4/2022, 9/2022 – 12/2022. • Individual #53 – None found for 4/2022 – 3/2023. • Individual #54 – None found for 4/2022 – 3/2023. • Individual #56 – None found for 9/2022 – 3/2023. • Individual #57 – None found for 4/2022 – 3/2023	

Tag # 4C15.1 Service Monitoring: Annual / Semi-Annual Reports & Provider Semi – Annual / Quarterly Report	Standard Level Deficiency	Standard Level Deficiency
NMAC 7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **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 requirement: 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: 6. The CM must monitor at least quarterly:	Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 39 of 57 individuals. Review of the Agency individual case files revealed no evidence of semi-annual reports for the following: **Supported Living Semi-Annual Reports:** • Individual #1 – None found for 3/2022 – 9/2022 *and* 9/2022 – 12/2022. *(Term of ISP 3/2022 – 2/2023. ISP meeting held 1/9/2023).* • Individual #4 – None found for 6/2022 – 12/2022. *(Term of ISP 6/2022 – 6/2023).* • Individual #6 – None found for 2/2022 – 8/2022 and 8/2022 – 11/2022. *(Term of ISP 2/2022 – 2/2023. ISP meeting held 12/1/2022).* • Individual #12 – None found for 4/2022 – 10/2022 and 10/2022 – 1/2023. *(Term of ISP 4/2022 – 4/2023. ISP meeting held 2/2023).* • Individual #14 – None found for 5/2022 – 8/2022. *(Term of ISP 11/2021 – 11/2022. ISP meeting held 8/22/3022).* • Individual #35 – None found for 6/2022 – 11/2022. *(Term of ISP 6/2022 – 5/2023).* • Individual #48 – None found for 1/2022 – 7/2022 and 7/2022 – 11/2022. *(Term of ISP 1/2022 – 1/2023. ISP meeting held 12/14/2022).* • Individual #56 – None found for 1/2022 – 4/2022. *(Term of ISP 7/2021 – 6/2022. ISP meeting held 4/19/2022).*	**New/Repeat Findings:** Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 5 of 52 individuals. Review of the Agency individual case files revealed no evidence of semi-annual reports for the following: **Supported Living Semi-Annual Reports:** • Individual #48 – None found for 1/2023 – 7/2023. *(Term of ISP 1/2023 – 1/2024).* **Family Living Semi-Annual Reports:** • Individual #19 – None found for 2/2023 – 7/2023. *(Term of ISP 2/2023 – 1/2024).* • Individual #44 – None found for 2/2023 – 4/2023. *(Term of ISP 7/14/2022 – 7/13/2023. ISP meeting held 4/22/2022).* **Nursing Semi - Annual Reports:** • Individual #46 – None found for 11/2022 – 2/2023. *(Term of ISP 5/2022 – 4/2023. ISP Meeting held 10/5/2022).* • Individual #53 – None found for 12/2022 – 3/2023. *(Term of ISP 6/2022 – 6/2023. ISP meeting held 3/30/2023).*

a. that all applicable current HCPs (including applicable CARMP), MERPs, Health Passport, PBSP or other applicable behavioral plans (such as PPMP or RMP), and WDSIs are in place in the applicable service sites. b. The content of each plan is to be reviewed for accuracy and discrepancies. c. 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. MERP's are determined by the e-chat and the BCIPs are determined by the critical behavioral needs as assessed by the BSC in collaboration with the IDT. d. a printed copy of Current Health Passport is required to be at all service delivery sites. 7. When risk of significant harm is identified, the CM follows. the standards outlined in Section II Chapter 18: Incident Management System. 8. The CM must report all suspected ANE as required by New Mexico Statutes and complete all follow up activities as detailed in Section II Chapter 18: Incident Management System. 9. If there are concerns regarding the health or safety of the person 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	**Family Living Semi-Annual Reports:** • Individual #2 – None found for 7/2022 – 12/2023. *(Term of ISP 7/2022 – 7/2023).* • Individual #19 – None found for 2/2022 – 7/2022 and 8/2022 – 10/2022. *(Term of ISP 2/2022 – 1/2023. ISP meeting held 11/11/2022).* • Individual #20 – None found for 5/2022 – 8/2022. *(Term of ISP 11/2021 – 10/2022. ISP meeting held 9/13/2022).* • Individual #24 – None found for 3/2022 – 98/2022 and 9/2022 – 1/2023. *(Term of ISP 3/2022 – 3/2023. ISP meeting held 1/18/2023).* • Individual #27 – None found for 12/2021 – 4/2022. *(Term of ISP 7/2021 – 6/2022. ISP meeting held 5/10/2021) and* 7/2022 – 12/2022. *(Term of ISP 7/2022 – 6/2023).* • Individual #28 – None found for 7/2022 – 12/2022. *(Term of ISP 7/2022 – 7/2023).* • Individual #30 – None found for 9/2022 – 11/2022. *(Term of ISP 3/2022 – 2/2023. ISP meeting held 11/17/2022).* • Individual #38 – None found for 11/2021 – 4/2022 and 4/2022 – 8/2022. *(Term of ISP 11/2021 – 10/2022. ISP meeting held 8/17/2022).* • Individual #41 – None found for 4/2022 – 7/2022. *(Term of ISP 10/2021 – 9/2022. ISP meeting held 7/27/2022)* and 10/2022 – 3/2023. *(Term of ISP 10/2022 – 9/2023).* • Individual #42 – None found for 2/2022 – 7/2022 and 7/2022 – 10/2022. *(Term of ISP 2/2022 – 1/2023. ISP meeting held 10/28/2022)*	

Section II 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…If additional support is needed, the CM notifies the DDSD Regional Office through the RORA process. 15. Case Management site visit must be documented in the DDSD published case note template in Therap and must be complete and submitted in Therap by the last day of the month in which the visit was completed.	• Individual #43 – None found for 12/2021 – 4/2022. *(Term of ISP 6/2021 – 6/2022. ISP meeting held 4/28/2022)* and 6/2022 – 11/2022. *(Term of ISP 6/2022 – 6/2023).* • Individual #44 – None found for 1/2022 – 3/2022. *(Term of ISP 7/2021 – 7/2022. ISP meeting held 4/2/2022)* and 7/2022 – 12/2023. *(Term of ISP 7/2022 – 7/2023).* • Individual #53 – None found for 12/2021 – 3/2022. *(Term of ISP 6/2021 – 6/2022. ISP meeting held 3/18/2022)* and *6/2022 – 11/2022. (Term of ISP 6/2022 – 6/2023.).* • Individual #54 – None found for 6/2022 – 11/2022. *(Term of ISP 6/2022 – 5/2023).* • Individual #55 – None found for 12/2021 – 3/2022. *(Term of ISP 6/2021 – 6/2022. ISP meeting held 4/7/2022)* and *6/2022 – 11/2022. (Term of ISP 6/2022 – 6/2023).* • Individual #57 – None found for 3/2022 – 6/2022. *(Term of ISP 9/2021 – 9/2022. ISP meeting held 6/25/2021) and* 9/2022 – 2/2023. *(Term of ISP 9/2022 – 9/2023).* **Intensive Medical Living Services Semi-Annual Reports:** • Individual #9 – None found for 10/2021 – 3/2022 and 3/2022 – 6/2022. *(Term of ISP 10/2021 – 9/2022. ISP meeting held 7/13/2022.)* • Individual #34 – None found for 6/2022 – 12/2022 and 12/2022 – 3/2023. *(Term of ISP 6/2022 – 6/2023. ISP meeting held 3/28/2023).* • Individual #46 – None found for 11/2022 – 2/2023. *(Term of ISP 5/2022 – 4/2023. ISP meeting held 3/1/2023).*	

	• Individual #52 – None found for 10/2021 – 4/2022 *and* 4/2022 – 8/2022. *(Term of ISP 10/2021 – 10/2022. ISP meeting held 9/8/2022).* **Customized In – Home Supports:** • Individual #3 – None found for 4/2022 – 9/2022 *and* 9/2022 – 1/2023. *(Term of ISP 4/2022 – 3/2023. ISP meeting held 2/2023).* • Individual #18 – None found for 2/2022 – 6/2022. *(Term of ISP 8/2021 – 8/2022. ISP meeting held 6/21/2022) and* 8/2022 – 2/2023. *(Term of ISP 8/2022 – 8/2023).* • Individual #25 – None found for 1/2022 – 6/2022 *and* 7/2022 – 10/2022. *(Term of ISP 1/2022 – 12/2022. ISP meeting held 10/27/2022).* • Individual #36 – None found for 11/2021 – 5/2022 *and* 5/2022 – 8/2022. *(Term of ISP 11/2021 – 11/2022. ISP meeting held 8/17/2022).* • Individual #47 – None found for 11/2021 – 5/2022. *(Term of ISP 11/2021 – 11/2022).* **Customized Community Supports Semi-Annual Reports:** • Individual #1 – None found for Customized Community Supports Group, for 3/2022 – 9/2022 *and* 9/2022 – 12/2022. *(Term of ISP 3/2022 – 2/2023. ISP meeting held 1/9/2023).* • Individual #2 – None found for 1/2022 – 4/2022. *(Term of ISP 7/2021 – 7/2022. ISP meeting held 4/20/2022) and* 7/2022 – 1/2023. *(Term of ISP 7/2022 – 7/2023).* • Individual #4 – None found for 6/2022 – 12/2022. *(Term of ISP 6/2022 – 6/2023).*	

	• Individual #6 – None found for 2/2022 – 8/2022 *and* 8/2022 – 11/2022. *(Term of ISP 2/2022 – 2/2023. ISP meeting held 12/1/2022)* • Individual #12 – None found for 4/2022 – 10/2022 *and* 10/2022 – 1/2023. *(Term of ISP 4/2022 – 4/2023. ISP meeting held 2/2023).* • Individual #14 – None found for 5/2022 – 8/2022. *(Term of ISP 11/2021 – 11/2022. ISP meeting held 8/22/2022).* • Individual #19 – None found for 2/2022 – 8/2022. *(Term of ISP 2/2022 – 1/2023).* • Individual #20 – None found for 5/2022 – 8/2022. *(Term of ISP 11/2021 – 10/2022. ISP meeting held 9/13/2022).* • Individual #24 – None found for 3/2022 – 9/2022 *and* 9/2022 – 11/2022. *(Term of ISP 3/2022 – 3/2023. ISP meeting held 11/17/2021).* • Individual #25 – None found for 1/2022 – 6/2022. *(Term of ISP 1/2022 – 12/2022).* • Individual #28 – None found for 7/2022 – 1/2023. *(Term of ISP 7/2022 – 7/2023).* • Individual #30 – None found for 3/2022 – 8/2022 *and* 9/2022 – 10/2022. *(Term of ISP 3/2022 – 2/2023. ISP meeting held 11/2022).* • Individual #34 – None found for 6/2022 – 12/2022. *(Term of ISP 6/2022 – 6/2023).* • Individual #35 – None found for 12/2021 – 3/2022. *(Term of ISP 6/2021 – 5/2022. ISP meeting held 3/2022) and* 6/2022 – 11/2022. *(Term of ISP 6/2022 – 5/2023).*	

	• Individual #38 – None found for 11/2021 – 4/2022 *and* 4/2022 – 8/2022. *(Term of ISP 11/2021 – 10/2022. ISP meeting held 8/17/2022).* • Individual #40 – None found for 11/2021 – 12/2022. *(Term of ISP 5/2021 – 5/2022. ISP meeting held 1/5/2021).* • Individual #41 – None found for 4/2022 – 7/2022 *(Term of ISP 10/2021 – 9/2022. ISP meeting held 7/27/2022) and* 10/2022 – 3/2023. *(Term of ISP 10/2022 – 9/2023).* • Individual #42 – None found for 2/2022 – 7/2022 *and* 7/2022 – 10/2022. *(Term of ISP 2/2022 – 1/2023. ISP meeting held 10/28/2022).* • Individual #43 – None found for 12/2021 – 3/2022. *(Term of ISP 6/2021 – 6/2022. ISP meeting held 4/8/2021) and* 6/2022 – 12/2022. *(Term of ISP 6/2022 – 6/2023).* • Individual #53 – None found for 6/2022 – 12/2022. *(Term of ISP 6/2022 – 6/2023).* • Individual #56 – None found for 1/2022 – 4/2022. *(Term of ISP 7/2021 – 6/2022. ISP meeting held 4/19/2022).* • Individual #57 – None found for 3/2021 – 6/2022. *(Term of ISP 9/2021 – 9/2022. ISP meeting held 6/25/2021) and* 9/2022 – 3/2023. *(Term of ISP 9/2022 – 9/2023).* **Community Integrated Employment Semi-Annual Reports:** • Individual #12 – None found for 4/2022 – 10/2022 and 10/2022 – 1/2023. *(Term of ISP 4/2022 – 4/2023. ISP meeting held 2/2023).* • Individual #18 – None found for 2/2022 – 6/2022. *(Term of ISP 8/2021 – 8/2022. ISP meeting held*	

	6/21/2022) and 8/2022 – 2/2023. *(Term of ISP 8/2022 – 8/2023).* • Individual #36 – None found for11/2021 – 5/2022 and 5/2022 – 8/2022. *(Term of ISP 11/2021 – 11/2022. ISP meeting held 8/2022).* **Nursing Semi - Annual Reports:** • Individual #1 – None found for 3/2022 – 9/2022 and 9/2022 – 12/2022. *(Term of ISP 3/2022 – 2/2023. ISP meeting held 1/9/2023).* • Individual #2 – None found for 1/2022 – 4/2022. *(Term of ISP 7/2021 – 7/2022. ISP meeting held 4/20/2022).* • Individual #4 – None found for 12/2021 – 2/2022. *(Term of ISP 6/2021 – 6/2022. ISP meeting held 2/23/2021)* and 6/2022 – 12/2022. *(Term of ISP 6/2022 – 6/2023).* • Individual #7 – None found for 8/2022 – 1/2023. *(Term of ISP 2/2022 – 1/2023. ISP meeting held 1/31/2023).* • Individual #9 – None found for 10/2021 – 3/2022 and 3/2022 – 6/2022. *(Term of ISP 10/2021 – 9/2022. ISP meeting held 7/13/2022).* • Individual #12 – None found for 4/2022 – 10/2022 and 10/2022 – 1/2023. *(Term of ISP 4/2022 – 4/2023. ISP meeting held 2/2023).* • Individual #13 – None found for 3/2022 – 9/2022 and 9/2022 – 12/2022. *(Term of ISP 3/2022 – 3/2023. ISP meeting held 12/20/2022).* • Individual #14 – None found for 5/2022 – 8/2022. *(Term of ISP 11/2021 – 11/2022. ISP meeting held 8/22/2022).*	

	• Individual #16 – None found for 3/2022 – 7/2022. *(Term of ISP 10/2021 – 9/2022. ISP meeting held 7/18/2022) and* 10/2022 – 3/2023. *(Term of ISP 10/2022 – 9/2023).* • Individual #23 – None found for 10/2021 – 5/2022 and 5/2022 – 8/2022. *(Term of ISP 10/2021 – 11/2022. ISP meeting held 8/22/2022).* • Individual #24 – None found for 3/2022 – 9/2022 and 9/2022 – 1/2023. *(Term of ISP 3/2022 – 3/2023. ISP meeting held 1/18/2023).* • Individual #25 – None found for 1/2022 – 6/2022 and for 7/2022 – 10/2022. *(Term of ISP 1/2022 – 12/2022. ISP meeting held 10/27/2022).* • Individual #33 – None found for 10/2021 – 4/2022. *(Term of ISP 10/2021 – 10/2022).* • Individual #35 – None found for 12/2021 – 3/2022. *(Term of ISP 6/2021 – 5/2022. ISP meeting held 3/2022)* and 6/2022 – 11/2022. *(Term of ISP 6/2022 – 5/2023).* • Individual #46 – None found for 11/2022 – 2/2023. *(Term of ISP 5/2022 – 4/2023. ISP meeting held 3/1/2022).* • Individual #52 – None found for 10/2021 – 4/2022. *(Term of ISP 10/2021 – 10/2022).* • Individual #53 – None found for 12/2021 – 3/2022. *(Term of ISP 6/2021 – 6/2022. ISP meeting held 3/18/2022)* and 6/2022 – 12/2022. *(Term of ISP 6/2022 – 6/2023).* • Individual #55 – None found for 12/2021 – 3/2022. *(Term of ISP 6/2021 – 6/2022. ISP meeting held 4/7/2022).*	

	• Individual #56 – None found for 1/2022 – 4/2022. *(Term of ISP 7/2021 – 6/2022. ISP meeting held 4/19/2022).*	

Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)	Condition of Participation Level Deficiency	Condition of Participation Level Deficiency
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 6: Individual Service Plan (ISP): 6.8 Completion and Distribution of the ISP:** The CM is required to assure all elements of the ISP, including signature page, and companion documents are completed and distributed to the IDT prior to the expiration of the ISP. DD Waiver Provider Agencies share responsibility to contribute to the completion of the ISP. ISP must be provided at least 14 calendar days prior to the effective day unless there is an issue with approval. The CM distributes the ISP including the TSS, to the DD Waiver Provider Agencies with a SFOC, as well as to all IDT members requested by the person. The CM distributes the ISP to the Regional Office. When TSS are not completed upon approval of the ISP, they must be distributed when available, no later than 14 calendar days prior to the beginning of the ISP term or the revision start date. **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;	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on record review the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 39 of 57 Individual: The following was found indicating the agency failed to provide a copy of the ISP to the Provider Agencies, Individual and / or Guardian at least 14 calendar days prior to the ISP effective date: **No Evidence found indicating ISP was distributed:** • Individual #1: ISP was not provided to Guardian / Individual. • Individual #3: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #4: ISP was not provided to Guardian / Individual. • Individual #5: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #6: ISP was not provided to Guardian / Individual. • Individual #12: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #13: ISP was not provided to Guardian / Individual. • Individual #16: ISP was not provided to Guardian / Individual, and LCA / CI Provider.	**New/Repeat Findings:** After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on record review the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 11 of 52 Individual: The following was found indicating the agency failed to provide a copy of the ISP to the Provider Agencies, Individual and / or Guardian at least 14 calendar days prior to the ISP effective date: **No Evidence found indicating ISP was distributed:** • Individual #27: ISP was not provided to Guardian / Individual. • Individual #35: ISP was not provided to Guardian / Individual. • Individual #39: ISP was not provided to LCA / CI Provider. • Individual #43: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #47: ISP was not provided to Guardian / Individual. • Individual #49: ISP was not provided to Guardian / Individual. • Individual #53: ISP was not provided to Guardian / Individual.

(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 ensure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.	• Individual #18: ISP was not provided to Individual. • Individual #19: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #20: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #22: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #23: ISP was not provided to Guardian / Individual. • Individual #24: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #27: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #29: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #30: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #31: ISP was not provided to Guardian / Individual. • Individual #32: ISP was not provided to Individual and CI Provider. • Individual #33: ISP was not provided to Guardian / Individual. • Individual #34: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #35: ISP was not provided to Guardian / Individual.	• Individual #54: ISP was not provided to Guardian / Individual. • Individual #56: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #57: ISP was not provided to Guardian / Individual. **Evidence indicated ISP was provided after 14-day window:** • Individual #35*: ISP effective date was 6/1/2023, ISP was sent to the LCA / CI Provider on 5/30/2023.* • Individual #41*: ISP effective date was 5/17/2023, ISP was sent to the Guardian / Individual, and LCA / CI Provider on 9/1/2023.* • Individual #49*: ISP effective date was 7/6/2023, ISP was sent to the LCA / CI Provider on 7/28/2023.* Per the Plan of Correction approved on 8/15/2023, "In order to ensure ongoing compliance a tracking sheet will be implemented and monitored by CM assistant supervisor. Copies of email or proof of receipt that ISP was distributed will be provided to the CM assistant supervisor for tracking purposes. In the event that case managers are not complying with this requirement, CM director will address this concern with the individual case manager and proceed with further disciplinary action as necessary." However, ISPs were not distributed to the Guardian / Individual and LCA / CI Providers within the required time frame for (#27, 35, 39, 41, 43, 44, 49, 53, 56, 57)

	• Individual #36: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #37: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #38: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #39: ISP was not provided to Guardian / Individual. • Individual #41: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #42: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #43: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #44: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #45: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #46: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #47: ISP was not provided to Guardian / Individual. • Individual #48: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #49: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #50: ISP was not provided to Guardian / Individual, and LCA / CI Provider.	

	• Individual #51: ISP was not provided to Guardian / Individual. • Individual #52: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #53: ISP was not provided to Guardian / Individual. • Individual #54: ISP was not provided to Guardian / Individual, and LCA / CI Provider. • Individual #55: ISP was not provided to Guardian / Individual. • Individual #56: ISP was not provided to Guardian / Individual. • Individual #57: ISP was not provided to Guardian / Individual, and LCA / CI Provider.	

Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)	Standard Level Deficiency	Standard Level Deficiency
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 6: Individual Service Plan (ISP): 6.8 Completion and Distribution of the ISP:** The CM is required to assure all elements of the ISP, including signature page, and companion documents are completed and distributed to the IDT prior to the expiration of the ISP. DD Waiver Provider Agencies share responsibility to contribute to the completion of the ISP. ISP must be provided at least 14 calendar days prior to the effective day unless there is an issue with approval. The CM distributes the ISP including the TSS, to the DD Waiver Provider Agencies with a SFOC, as well as to all IDT members requested by the person. The CM distributes the ISP to the Regional Office. When TSS are not completed upon approval of the ISP, they must be distributed when available, no later than 14 calendar days prior to the beginning of the ISP term or the revision start date. **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;	Based on record review the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 42 of 57 Individual: The following was found indicating the agency failed to provide a copy of the ISP to the respective DDSD Regional Office at least 14 calendar days prior to the ISP effective date: **No Evidence found indicating ISP was distributed to the regional office:** • Individual #3 • Individual #4 • Individual #5 • Individual #6 • Individual #9 • Individual #11 • Individual #12 • Individual #13 • Individual #15 • Individual #16 • Individual #18 • Individual #19 • Individual #20 • Individual #22	**New/Repeat Findings:** Based on record review the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 9 of 52 Individual: The following was found indicating the agency failed to provide a copy of the ISP to the respective DDSD Regional Office at least 14 calendar days prior to the ISP effective date: **No Evidence found indicating ISP was distributed to the regional office:** • Individual #35 • Individual #43 • Individual #48 • Individual #57 **Evidence indicated ISP was provided after 14-day window:** • Individual #15*: ISP effective date was 9/11/2023, ISP was sent to the DDSD Regional Office on 10/12/2023.* • Individual #27*: ISP effective date was 7/1/2023, ISP was sent to the DDSD Regional Office on 7/1/2023.* • Individual #39*: ISP effective date was 8/22/2023, ISP was sent to the DDSD Regional Office on 8/23/2023.* • Individual #41*: ISP effective date was 5/14/2023, ISP was sent to the DDSD Regional Office on 9/1/2023.*

(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 ensure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.	• Individual #23 • Individual #24 • Individual #27 • Individual #29 • Individual #30 • Individual #32 • Individual #34 • Individual #35 • Individual #36 • Individual #37 • Individual #38 • Individual #39 • Individual #41 • Individual #42 • Individual #43 • Individual #44 • Individual #45 • Individual #46 • Individual #47 • Individual #48 • Individual #49	• Individual #44*: ISP effective date was 7/14/2023, ISP was sent to the DDSD Regional Office on 8/18/2023.* Per the Plan of Correction approved on 8/15/2023, "In order to ensure ongoing compliance a tracking sheet will be implemented and monitored by CM assistant supervisor. Copies of email or proof of receipt that ISP was distributed will be provided to the CM assistant supervisor for tracking purposes. In the event that case managers are not complying with this requirement, CM director will address this concern with the individual case manager and proceed with further disciplinary action as necessary." However, QA/ QI was not completed to ensure ISPs were distributed to DDSD within the required time frame (#15, 27, 35, 39, 41, 43, 44, 48, 57).

	• Individual #50 • Individual #51 • Individual #52 • Individual #53 • Individual #54 • Individual #57 **Evidence indicated ISP was provided after 14-day window:** • Individual #33*: ISP effective date was 10/17/2022, ISP was sent to the DDSD Regional Office on 10/19/2022.*	

Standard of Care	Routine Survey Deficiencies April 10 – 21, 2023	Verification Survey New and Repeat Deficiencies October 10 – 18, 2023
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses, and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	**Condition of Participation Level Deficiency**	**Standard Level Deficiency**

Developmental Disabilities Waiver Service Standards Eff 11/1/2021
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 requirement:
3. The case file must contain the documents identified in Appendix A: Client File Matrix.
	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 29 of 57 individuals.
	
	Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:
	
	Electronic Comprehensive Health Assessment Tool:
	• Not Found (#22, 35, 52, 56)
	
	• Not Current (#4)
	
	eCHAT Summary:
	• Not Current (#4)
	
	Aspiration Risk Screening Tool (ARST):
	• Not Found (#12, 22, 24, 27, 35, 53)
	
	• Not Current (#4, 19, 44, 48)
	
	Comprehensive Aspiration Risk Management Plan*:*
	• Not Found (#4, 49)
	
	Health Care Plans:
	• *Anxiety*
	  • Individual #1 - As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of the plan was found.
		New/Repeat Findings:
		
		Based on record review, the Agency did not maintain a complete client record at the administrative office for 2 of 52 individuals.
		
		Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:
		
		Aspiration Risk Screening Tool (ARST):
		• Not Found (#12)
		
		Health Care Plans:
		• *Constipation Management*
		  • Individual #41 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found.
		
		• *Falls*
		  • Individual #41 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found.
		
		• *Seizure Disorder*
		  • Individual #41 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found.

	• *Body Mass Index*
	  • Individual #1 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found.
	  • Individual #12 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found.
	  • Individual #52 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current.
	• *Chronic Pain*
	  • Individual #4 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current.
	• *Communication Deficit*
	  • Individual #1 - As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of the plan was found.
	• *Constipation*
	  • Individual #4 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current.
	  • Individual #41 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found.
	• *Fall Risk / Injury*
	  • Individual #1 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found.
	  • Individual #4 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current.	

	• Individual #41 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found. • *Gastrointestinal / Reflux* • Individual #4 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • *Leukopenia* • Individual #1 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found. • *Lithium Toxicity* • Individual #4 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • *PRN Medication* • Individual #4 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • *Protective Head Gear* • Individual #1 - As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of the plan was found. • *Respiratory* • Individual #12 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found. • *Risk for Infection* • Individual #2 - As indicated by the ISP section of the ISP the individual is required to have a plan. No evidence of the plan was found. • *Seizure Disorder*	

	• Individual #1 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found. • Individual #41 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found. • *Skin Integrity* • Individual #1 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found. • Individual #2 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found. • Individual #52 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. **Medical Emergency Response Plans:** • *Allergy – Bee Stings* • Individual #23 - As indicated by the eCHAT No evidence of the plan was found. • *Aspiration Risk* • Individual #1 - As indicated by the eCHAT No evidence of the plan was found. • Individual #4 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • Individual #9 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • Individual #12 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found.	

	• Individual #23 - As indicated by the eCHAT No evidence of the plan was found. • Individual #33 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • Individual #37 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • *Bowel and Bladder / Constipation* • Individual #12 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found. • *Diabetes* • Individual #37 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • *Drug Allergy* • Individual #1 - As indicated by the eCHAT No evidence of the plan was found. • Individual #33 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • *Fall Risk* • Individual #1 - As indicated by the eCHAT No evidence of the plan was found. • Individual #4 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • Individual #41 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found.	

	• Individual #56 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • *High Risk Medication* • Individual #13 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • *Leukopenia* • Individual #1 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found. • *Respiratory / Asthma* • Individual #2 – As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of the plan was found. • Individual #12 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found. • Individual #37 - As indicated by the IST section of the ISP the individual is required to have a plan. The plan provided was not current. • *Seizure Disorder* • Individual #1 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found. • Individual #2 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found. • Individual #23 - As indicated by the eCHAT No evidence of the plan was found. • Individual #41 - As indicated by the eCHAT the individual is required to have a plan. No evidence of the plan was found.	

	• *Skin Breakdown*
	  • Individual #53 – As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of the plan was found.
	
	Other Plans Required by the Individual:
	
	Nutritional Plan:
	  • Individual #1 - As indicated by collateral documentation reviewed, the individual is required to have a plan. No evidence of plan found.
	
	  • Individual #5 - As indicated by collateral documentation reviewed, the individual is required to have a plan. No evidence of plan found.
	
	  • Individual #6 - As indicated by collateral documentation reviewed, the individual is required to have a plan. No evidence of plan found.
	
	  • Individual #12 - As indicated by collateral documentation reviewed, the individual is required to have a plan. No evidence of plan found.
	
	  • Individual #13 - As indicated by collateral documentation reviewed, the individual is required to have a plan. No evidence of plan found.
	
	  • Individual #28 - As indicated by collateral documentation reviewed, the individual is required to have a plan. No evidence of plan found.
	
	  • Individual #52 - As indicated by collateral documentation reviewed, the individual is	

	required to have a plan. No evidence of plan found.	

Standard of Care	Routine Survey Deficiencies April 10 – 21, 2023	Verification Survey New and Repeat Deficiencies October 10 – 18, 2023
Service Domain: Plan of Care - ISP Development & Monitoring – *Service plans address all participants' 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**	**COMPLETE**
Tag # 1A08.4 Assistive Technology Inventory List	**Standard Level Deficiency**	**COMPLETE**
Tag # 4C01.1 Case Management Services – Utilization of Services	**Standard Level Deficiency**	**COMPLETE**
Tag # 4C02 Scope of Services - Primary Freedom of Choice	**Standard Level Deficiency**	**COMPLETE**
Tag # 4C07 Individual Service Planning *(Visions, measurable outcome, action steps)*	**Standard Level Deficiency**	**COMPLETE**
Tag # 4C07.2 Person Centered Assessment and Career Development Plan	**Standard Level Deficiency**	**COMPLETE**
Tag # 4C08 ISP Development Process	**Standard Level Deficiency**	**COMPLETE**
Tag # 4C10 Approved Budget Worksheet Waiver Review Form / MAD 046	**Standard Level Deficiency**	**COMPLETE**
Tag # 4C12.1 Monitoring & Evaluation of Services (IDT Meetings for Significant Life Events)	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Level of Care – *Initial and annual Level of Care (LOC) evaluations are completed within timeframes specified by the State.*		
Tag # 4C04 Assessment Activities	**Condition of Participation Level Deficiency**	**COMPLETE**
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***	**COMPLETE**
Tag # 1A28.4 Incident Mg: Case Manager Knowledge Case Manager Knowledge of Responsibility of IMB Notification	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses, and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Condition of Participation Level Deficiency**	**COMPLETE**
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 # 4C21 Case Management Reimbursement	**Standard Level Deficiency**	**COMPLETE**

	Verification Survey Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components	**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 # 4C09 Secondary FOC	**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 # 4C12 Monitoring & Evaluation of Services	**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 # 4C15.1 Service Monitoring: Annual / Semi-Annual Reports & Provider Semi – Annual / Quarterly Report	**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 # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, 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?)***:** →	
Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)	**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 # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	**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?)***:** →	

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date: December 21, 2023

To: Sarah Herrington, Case Management Director / Case Manager

Provider: J & J Home Care, Inc.
Address: 105 West 3rd St.
State/Zip: Roswell, New Mexico 88201

E-mail Address: sarahp@jjhc.org

Region: Southeast
Routine Survey: April 10 – 21, 2023
Verification Survey: October 10 – 18, 2023

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Case Management

Survey Type: Verification

Dear Ms. Herrington,

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.24.2.DDW.D4045.4.001.VER.09.23.355