NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date:	October 30, 2023
To:	Melinda Broussard, Executive Director / Case Manager
Provider:	A Step Above Case Management, Corporation
Address:	2716 San Pedro NE, Ste. A
State/Zip:	Albuquerque, New Mexico 87110
E-mail Address:	jelliebeans6869@gmail.com
Region:	Metro, Northeast, Northwest, Southwest
Survey Date:	September 25 – October 11, 2023
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Case Management
Survey Type:	Routine
Team Leader:	Lundy Tvedt, BA, JD, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau
Team Members:	Sally Karingada, BS, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau; Heather Driscoll, AA, AAS, Division of Health Improvement/Quality Management Bureau; Verna Newman-Sikes, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Kaitlyn Taylor, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Broussard:

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

Determination of Compliance:

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

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

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

The following tags are identified as Condition of Participation Level:

- Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian) ***(Modified by IRF)***
- Tag # 1A26.1 Employee Abuse Registry ***(Removed by IRF)***

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File ***(Modified by IRF)***
- Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components ***(Modified by IRF)***
- Tag # 4C01.1 Case Management Services – Utilization of Services
- Tag # 4C02 Scope of Services - Primary Freedom of Choice ***(Removed by IRF)***
- Tag # 4C07 Individual Service Planning *(Visions, measurable outcome, action steps)*
- Tag # 4C07.1 Individual Service Planning – Paid Services
- Tag # 4C07.2 Person Centered Assessment and Career Development Plan ***(Removed by IRF)***
- Tag # 4C09 Secondary FOC ***(Modified by IRF)***
- Tag # 4C12 Monitoring & Evaluation of Services ***(Modified by IRF)***
- Tag # 4C15.1 Service Monitoring: Annual / Semi-Annual Reports & Provider Semi – Annual Reports
- Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office) ***(Modified by IRF)***
- Tag # 4C04 Assessment Activities ***(Modified by IRF)***
- Tag # 4C05 Review & Approval of the LTCAA by TPA ***(Removed by IRF)***
- Tag # 1A22 / 4C02 Case Manager: Individual Specific Competencies
- Tag # 1A26 Employee Abuse Registry ***(Modified by IRF)***
- Tag # 4C17.1 Case Manager Qualifications: Credentials ***(Removed by IRF)***
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap® and Required Plans)

Plan of Correction:

The attached Report of Findings identifies the deficiencies found during your agency's on-site compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (Attachment A) for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

Corrective Action for Current Citation:

- How is the deficiency going to be corrected? (e.g., obtained documents, retrain staff, individuals and/or staff no longer in service, void/adjusts completed, etc.) This can be specific to each deficiency cited or if possible, an overall correction, e.g., all documents will be requested and filed as appropriate.

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done on an ongoing basis? (e.g., file reviews, etc.)
- How many individuals is this going to affect? (e.g., percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (e.g., weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position within your agency)
- What steps will be taken if issues are found? (e.g., retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction in the available space on the two right-hand columns of the Report of Findings. *(See attachment "A" for additional guidance in completing the Plan of Correction)*.

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

1. **Quality Management Bureau, Monica Valdez, Plan of Correction Coordinator** at MonicaE.Valdez@doh.nm.gov

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

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Billing Deficiencies:

If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a "Void/Adjust" claim or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: *Lisa Medina-Lujan*
HSD/OIG/Program Integrity Unit
PO Box 2348
1474 Rodeo Road
Santa Fe, New Mexico 87505

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

Lisa Medina-Lujan (Lisa.medina-lujan@hsd.nm.gov)

Please be advised that there is a one-week lag period for applying payments received by check to Void/Adjust claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

Request for Informal Reconsideration of Findings (IRF):

If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

ATTN: QMB Bureau Chief
Request for Informal Reconsideration of Findings
5300 Homestead Rd NE, Suite 300 - 3223
Albuquerque, NM 87110
Attention: IRF request/QMB

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@doh.nm.gov 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,

Lundy J Tvedt, BA, JD

Lundy J Tvedt, BA, JD
Team Lead/Healthcare Surveyor Supervisor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	September 25, 2023
Contact:	**A Step Above Case Management, Corporation** Melinda Broussard, Executive Director / Case Manager **DOH/DHI/QMB** Lundy Tvedt, BA, JD, Team Lead / Healthcare Surveyor Supervisor
On-site Entrance Conference Date:	September 25, 2023
Present:	**A Step Above Case Management, Corporation** Melinda Broussard, Executive Director / Case Manager Jackie McKenna, Compliance Director Sabrina James, Case Manager **DOH/DHI/QMB** Lundy Tvedt, BA, JD, Team Lead / Healthcare Surveyor Supervisor Sally Karingada, BS, Healthcare Surveyor Supervisor Verna Newman-Sikes, AA, Healthcare Surveyor Kaityln Taylor, BSW, Healthcare Surveyor
Exit Conference Date:	October 6, 2023
Present:	**A Step Above Case Management, Corporation** Melinda Broussard, Executive Director / Case Manager **DOH/DHI/QMB** Lundy Tvedt, BA, JD, Team Lead/Healthcare Surveyor Supervisor Amanda Casteñeda-Holguin, MPA, Healthcare Surveyor Supervisor Verna Newman-Sikes, AA, Healthcare Surveyor Kaityln Taylor, BSW, Healthcare Surveyor Heather Driscoll, AA, AAS, Healthcare Surveyor **DDSD – NW /S W Regional Offices** Isabel Casaus, DDSD SW Regional Director Michele Groblebe, DDSD NW Regional Director
Administrative Locations Visited:	1 *(Administrative portion of survey completed remotely)*
Total Sample Size:	52 8 - *Former Jackson Class Members* ~~44~~ - Non-Jackson Class Members
Persons Served Records Reviewed	52
Total Number of *Secondary Freedom of Choices* Reviewed:	Number: 215
Case Management Personnel Records Reviewed	28
Case Manager Personnel Interviewed	28

Administrative Interview 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 make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be

implemented, and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and

5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@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, e.g., 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 –** Apprv. Budget Worksheet Waiver Review Form / MAD 046
- **4C12 –** Monitoring & Evaluation of Services
- **4C16 –** Requirements for Reports & Distribution of ISP (Provider Agencies, Individual and/or Guardian)

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

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

- **4C04 –** Assessment Activities

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

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

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

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

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

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

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

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

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

- **1A05 –** General Requirements

Attachment C

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

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

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB 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: Microsoft Word - IRF-QMB-Form.doc (nmhealth.org)
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 on the decisions of the IRF committee.

Attachment D

QMB Determinations of Compliance

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of *Compliance*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

Partial-Compliance with Standard Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags* indicates that a provider is in compliance with all Condition of Participation Level deficiencies but is out of compliance with a certain percentage of Standard Level deficiencies. This partial compliance, if not corrected, may result in a negative outcome or the potential for more than minimal harm to individuals' health and safety. There are two ways to receive a determination of Partial Compliance with Standard Level Tags:

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.

2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. This partial compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety.

Non-Compliance:

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 17 or more total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level tag.

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

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

Agency: **A Step Above Case Management, Corporation - Metro, Northwest, Northeast, Southwest Regions**
Program: Developmental Disabilities Waiver
Service: Case Management
Survey Type: Routine
Survey Date: **September 25 – October 11, 2023**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
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 ***(Modified by IRF)***	**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… **Chapter 20: Provider Documentation and Client Records: 20.1 HIPAA:** DD Waiver Provider Agencies shall comply with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH). All DD Waiver Provider Agencies are required to store information and have adequate procedures for maintaining the privacy and the security of individually identifiable health information. HIPPA compliance extends to electronic and virtual platforms. **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	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: ~~**Speech Therapy Initial / Re-Evaluation Report:**~~ • ~~Not Found (#50)~~ *(Removed by IRF Individual #50)* ~~**Occupational Therapy Plan:**~~ • ~~Not Found (#31)~~ *(Removed by IRF Individual #31)* ~~**Physical Therapy Plan:**~~ • ~~Not Found (#31)~~ *(Removed by IRF Individual #31)* **Guardianship Documentation:** • Not Found (#10, 49)	**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?)*: →	

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. 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 # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components *(Modified by IRF)*	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; 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	Based on record review, the Agency did not maintain a complete client record at the administrative office for 6 of 52 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: ~~**Addendum A w/ *Incident Mgt. System - Parent/Guardian Training*:**~~ • ~~Not Found (#31)~~ *(Removed by IRF Individual #31)* **ISP Teaching & Support Strategies:** ***Individual #24:*** *TSS not found for the following Fun / Relationships; Outcome Statement / Action Steps:* • "When offered the choice of 2 activities ... will choose which activity, she wants to complete." • "...will participate in the activity of her choosing." • "...will choose and participate in a community activity with peers." ***Individual #35:*** *TSS not found for the following Work / Learn Outcome Statement / Action Steps:* • "...will wash and dry his work uniforms." ***Individual #39:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "...will choose a holiday theme to decorate the house."	**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?)*: →	

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.	• "...with assistance will purchase items to decorate the house." ***Individual #41:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "... will practice the song 8x's per month." *TSS not found for the following Work / Learn Outcome Statement / Action Steps:* • "... will workout for 30 minutes." *(Upheld by IRF Individual #41)* **ISP Assessment Checklist:** • Not Found (#52)		

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. 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 # 4C01.1 Case Management Services – Utilization of Services	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 8 Case Management: 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… 13. 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.	Based on record review, the Agency did not have evidence indicating they were monitoring the utilization of budgets for DDW services for 2 of 52 individuals. **Budget Utilization Report:** Individual #38 – *The following was found indicating low or no usage during the term of the ISP budget 2/1/2023 – 1/31/2024, no evidence was found indicating why the usage was low and/or no usage:* • CCS-I [H2021 HB - U1]: 9000 units approved; 861 units used from *2/1/2023* (budget start date) to *9/22/2023* (utilization report run). • CIES [T2013 HB - U2]: 30 units approved; 0 units used from *2/1/2023* (budget start date) to *9/22/2023* (utilization report run). • CIES [T2025 HB - UA]: 12 units approved; 2 units used from *2/1/2023* (budget start date) to *9/22/2023* (utilization report run). • BSC [H2019 HB]: 200 units approved; 40 units used from *2/1/2023* (budget start date) to *9/22/2023* (utilization report run). • SLP [G0153 HB - GN]: 188 units approved; 0 units used from *2/1/2023* (budget start date) to *9/22/2023* (utilization report run). Individual #44 – *The following was found indicating low or no usage during the term of the ISP budget 10/1/2022 – 9/30/2023, no evidence was found indicating why the usage was low and/or no usage:*	**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?)***:** →	

	• CCSI [H2021 HB - U1]: 2640 units approved; 1404 units used from *10/1/2022* (budget start date) to *9/22/2023* (utilization report run). • SLP [G0153 HB – TN]: 204 units approved; 61 units used from *10/1/2022* (budget start date) to *9/22/2023* (utilization report run).		

Tag # 4C02 Scope of Services - Primary Freedom of Choice *(Removed by IRF)*	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 1: Initial Allocation and Ongoing Eligibility: 1.4 Primary Freedom of Choice (PFOC):~~** ~~The applicant completes the PFOC form to select between:~~ ~~1. An Intermediate Care Facility for Individuals with Intellectual/Developmental Disability (ICF/IID); or~~ ~~2. The DD Waiver and a Case Management Agency or the Mi Via Self-Directed Waiver and a Consultant Agency.~~ ~~3. To place their allocation on hold or refuse the allocation:~~ ~~a. The applicant retains their original registration date. The applicant later needs to contact DDSD to take the allocation off hold at which time the applicant would be actively awaiting allocation based on their original registration date and available funding; or~~ ~~b. The applicant chooses not to receive services through ICF/IID nor DD Waiver or Mi Via now or in the future. The allocation will be closed, with a notice of rights to an Administrative Fair Hearing, and the applicant would need to re-apply for HCBS with a new registration date should they choose to seek services in the future.~~	~~Based on record review, the Agency did not maintain documentation assuring individuals obtained all services through the freedom of choice process for 1 of 52 individuals.~~ ~~Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:~~ **~~Primary Freedom of Choice:~~** ~~• Not Found (#50)~~ *(Removed by IRF Individual #50)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Chapter 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. **Chapter 9 Transitions:** Individuals may choose to change services, provider agencies, waiver programs, or even withdraw altogether from waiver services. Although a resumption of services may ultimately occur, individuals may also be discharged, have services suspended, or be terminated from the DD Waiver under various circumstances. In any of these circumstances, appropriate planning must occur, and information must be provided to facilitate a smooth transition and informed choices. The CM plays a critical role in all types of transitions. **9.9 Waiver Transfers:** A DD Waiver participant and/or legal representative may choose to transfer to or from another waiver program by contacting the DDSD to initiate a waiver change. If a person wants to switch waivers within the first 30 calendar days of allocation, and no medical or financial eligibility has begun, the transfer is permitted. Waiver transfers are not allowed when the expiration of the person's LOC is within 90 calendar days or less. If the participant has already begun the eligibility or annual recertification process, the person must meet medical and financial eligibility before they may request a transfer. Waiver transfers require the following steps: 1. A Waiver Change Form (WCF) is completed by the person and/or legal			

~~representative and returned to the local DDSD Regional Office.~~ ~~2. Once DDSD staff receive the WCF, it is forwarded by DDSD staff to the current DD Waiver CM, Medically Fragile CM, and Mi Via Consultant as relevant.~~ ~~3. Transfers between waivers should occur within 90 calendar days of receipt of the WCF unless there are circumstances related to the person's services that require more time.~~ ~~4. Transition meetings must occur within at least 30 calendar days of receipt of the WCF. The receiving agency must schedule the meeting within five days of receipt of the WCF.~~ ~~5. The transition meeting must occur, either by phone or in person, and is required to include the person or their legal representative, as well as the Mi Via Consultant or Medically Fragile Case Manager and DD Waiver CM who attend in person.~~			

Tag # 4C07 Individual Service Planning *(Visions, measurable outcome, action steps)*	Standard Level Deficiency		
NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS: Each ISP shall contain. B. Long term vision: The vision statement shall be recorded in the individual's actual words, whenever possible. For example, in a long-term vision statement, the individual may describe him or herself living and working independently in the community. C. Outcomes: (1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long-term vision. The IDT determines the intensity, frequency, duration, location, and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP. (2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver. D. Individual preference: The individual's preferences, capabilities, strengths and needs in	Based on record review, the Agency did not ensure the ISP was developed in accordance with the rule governing ISP development, for 2 of 52 Individuals. The following was found with regards to ISP: **Individual #28:** • Live Outcome: "...will have planted some plants of her choice and care for them." Outcome was not measurable, as it did not indicate how and/or when it would be completed. • Fun Outcome: "...will choose a gym and exercise 2x a week." Outcome was not measurable, as it did not indicate how and/or when it would be completed. **Individual #33:** • Vision for Live, "Someday in the future, ...would like to have a place of his own." Outcome indicates, "...will cooperate with attending necessary medical appointments." Review of ISP found outcome is not tied to the person's vision statement. • Fun Outcome: "...will participate in a weekly activity outside of his home and in the community." Outcome was not measurable, as it did not indicate how and/or when it would be completed.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

each life area determined to be relevant to the identified ISP outcomes shall be reflected in the ISP. The long-term vision, age, circumstances, and interests of the individual, shall determine the life area relevance, if any to the individual's ISP. E. Action plans: (1) Specific ISP action plans that will assist the individual in achieving each identified, desired outcome shall be developed by the IDT and stated in the ISP. The IDT establishes the action plan of the ISP, as well as the criteria for measuring progress on each action step. (2) Service providers shall develop specific action plans and strategies (methods and procedures) for implementing each ISP desired outcome. Timelines for meeting each action step are established by the IDT. Responsible parties to oversee appropriate implementation of each action step are determined by the IDT. (3) The action plans, strategies, timelines and criteria for measuring progress, shall be relevant to each desired outcome established by the IDT. The individual's definition of success shall be the primary criterion used in developing objective, quantifiable indicators for measuring progress. Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 4: Person-Centered Planning (PCP): 4.1 Essential Elements of Person-Centered Planning (PCP):** Person-centered planning is a process that places a person at the center of planning their life and supports. The CMS requires use of PCP in the development of the ISP. It is an ongoing process that is the foundation for all aspects of the DD Waiver Program and DD Waiver Provider Agencies' work with people with I/DD. The process is designed to identify the strengths, capacities, preferences, and needs of the person. The process may include other people chosen by the person, who are able to serve as important contributors to the process. Overall, PCP			

involves person-centered thinking, person-centered service planning, and person-centered practice. PCP enables and assists the person to identify and access a personalized mix of paid and non-paid services and supports to assist him or her to achieve personally defined outcomes in the community. **Chapter 6: Individual Service Plan (ISP):** **6.6.1 Vision Statements:** The long-term vision statement describes the person's major long-term (e.g., within one to three years) life dreams and aspirations in the following areas: 1. Live, 2. Work/Education/Volunteer, 3. Develop Relationships/Have Fun, and 4. Health and/or Other (Optional). **6.6.2 Desired Outcomes:** A Desired Outcome is required for each life area (Live, Work, Fun) for which the person receives paid supports through the DD Waiver. Each service does not need its own, separate outcome, but should be connected to at least one Desired Outcome. Desired outcomes must: 1. be directly linked to a Vision; 2. be meaningful; 3. be measurable; 4. allow for skill building or personal growth; 5. be desired by the person, other team members; 6. not contain "readiness traps" or artificial barriers and steps others would not need to complete to pursue desired goals; and 7. not be achievable with little to no effort (e.g., open a savings account or one-time action).			

Tag # 4C07.1 Individual Service Planning – Paid Services	Standard Level Deficiency		
NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS: Each ISP shall contain…C. Outcomes: (1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP. (2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver. Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 4: Person-Centered Planning (PCP): 4.1 Essential Elements of Person-Centered Planning (PCP):** Person-centered planning is a process that places a person at the center of planning their life and supports.	Based on record review, the Agency did not ensure Case Managers developed outcomes for the individual for each paid service for 1 of 52 Individuals. The following was found with regards to ISP Outcomes: **Individual #9:** • No Outcomes or DDSD exemption/decision justification found for Supported Living Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver."	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

The CMS requires use of PCP in the development of the ISP. It is an ongoing process that is the foundation for all aspects of the DD Waiver Program and DD Waiver Provider Agencies' work with people with I/DD. The process is designed to identify the strengths, capacities, preferences, and needs of the person. The process may include other people chosen by the person, who are able to serve as important contributors to the process. Overall, PCP involves person-centered thinking, person-centered service planning, and person-centered practice. PCP enables and assists the person to identify and access a personalized mix of paid and non-paid services and supports to assist him or her to achieve personally defined outcomes in the community. **Chapter 6: Individual Service Plan (ISP):** **6.6.2 Desired Outcomes:** A Desired Outcome is required for each life area (Live, Work, Fun) for which the person receives paid supports through the DD Waiver. Each service does not need its own, separate outcome, but should be connected to at least one Desired Outcome. Desired outcomes must: 1. be directly linked to a Vision; 2. be meaningful; 3. be measurable; 4. allow for skill building or personal growth; 5. be desired by the person, other team members; 6. not contain "readiness traps" or artificial barriers and steps others would not need to complete to pursue desired goals; and 7. not be achievable with little to no effort (e.g., open a savings account or one-time action).			

Tag # 4C07.2 Person Centered Assessment and Career Development Plan *(Removed by IRF)*	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 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.~~ ~~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.~~ ~~**Chapter 11: Community Inclusion: 11.4**~~ ~~Person Centered Assessments (PCA) and Career Development Plans (CDP)~~ ~~Agencies who are providing CCS and/or CIE are required to complete a person-centered assessment (PCA). A PCA is a person-centered planning tool that is intended to be used for the service agency to get to know the person whom they are supporting and to help identify the individual needs and strengths to~~	~~Based on record review, the Agency did not maintain a complete case file at the administrative office for 1 of 52 individuals.~~ ~~Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:~~ ~~**Person Centered Assessment:**~~ ~~• Not Found (#31)~~ *(Removed by IRF Individual #31)*	**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?)*: →	

~~be addressed in the ISP. The PCA should provide the reader with a good sense of who the person is and is a means of sharing what makes an individual unique. The information gathered in a PCA should be used to guide community inclusion services for the individual. Recommended methods for gathering information include paper reviews, interviews with the individual, guardian or anyone who knows the individual well including staff, family members, friends, BSC therapist, school personnel, employers, and providers. Observations in the community, home visits, neighborhood/environmental observations research on community resources, and team input are also reliable means of gathering valuable information. A Career Development Plan (CDP), developed by the CIE Provider Agency with input from the CCS Provider, must be in place for job seekers or those already working to outline the tasks needed to obtain, maintain, or seek advanced opportunities in employment.~~ ~~3. Timelines for completion: The initial PCA must be completed within the first 90 calendar days of the person receiving services. Thereafter, the Provider Agency must ensure that the PCA is reviewed and updated with the most current information, annually. A more extensive update of a PCA must be completed every five years. PCAs completed at the 5-year mark should include a narrative summary of progress toward outcomes from initial development, changes in support needs, major life changes, etc. If there is a significant change in a person's circumstance, a new PCA should be considered because the information in the PCA may no longer be relevant. A significant change may include but is not limited to losing a job, changing a~~			

~~residence or provider, and/or moving to a new region of the state.~~ 6. ~~A career development plan is developed by the CIE provider with input from the CCS provider, as appropriate, and can be a separate document or be added as an addendum to a PCA. The career development plan should have specific action steps that identify who does what and by when.~~			

Tag # 4C09 Secondary FOC *(Modified by IRF)*	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**	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 6 of 52 individuals. Review of the Agency individual case files revealed 6 out of 215 Secondary Freedom of Choices were not found and/or not agency specific to the individual's current services: **Secondary Freedom of Choice:** • Family Living (#27) • Customized Community Supports (#24, 40) • Occupational Therapy (#~~31,~~ 52) *(Removed by IRF Individual #31)* • Adult Nursing Services (#17, 41)	**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?)*: →	

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: 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 *(Modified by IRF)*	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. **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 (e.g.,, 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	Based on record review, the Agency did not use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual for 4 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 #9 – No Face to Face Therap ® Monthly Site Visit Form found for 5/2023. **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 #32** (Non-Jackson) No site visit was noted between 9/2022 - 12/2022. • 9/21/2022 – 5:30pm – Location: home • 10/13/2022 – 5:00pm – Location: home • 11/4/2022 – 10:00am – Location: home • 12/12/2022 – 10:00am – Location: home **Individual #40** (Non-Jackson) No site visit was noted between 3/2023 & 5/2023 - 8/2023. • 3/13/2023 – 12:00pm – Location: home • 5/24/2023 – 3:45pm – Location: home • 6/26/2023 – 1:30pm – Location: home	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

contact for adults (including JCMs) living in the community. 5. For non-JCMs, face-to-face visits must occur as follows: a. At least one face-to-face visit per quarter shall occur at the person's home for people who receive a Living Supports or CIHS. b. At least one face-to-face visit per quarter shall occur at the day program for people who receive CCS and or CIE in an agency operated facility. c. It is appropriate to conduct face-to-face visits with the person either during times when the person is receiving a service or during times when the person is not receiving a service. d. The CM considers preferences of the person when scheduling face-to face-visits in advance. e. Face-to-face visits may be unannounced depending on the purpose of the monitoring. 6. The CM must monitor at least quarterly: a. that 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	• 7/17/2023 – 2:30pm – Location: home • 8/7/2023 – 12:15pm – Location: home **Review of the Agency individual case files revealed no evidence of Case Manager Monthly Contact Case Notes for the following:** • Individual #5 - None found for 4/2023. ~~• Individual #50 - None found for 9/2023, 3/2023, and 4/2023.~~ *(Removed by IRF Individual #50)*		

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 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. 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.			

Tag # 4C15.1 Service Monitoring: Annual / Semi-Annual Reports & Provider Semi – Annual / Quarterly Report	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.	Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 9 of 52 individuals. Review of the Agency individual case files revealed no evidence of semi-annual reports for the following: **Family Living Semi-Annual Reports:** • Individual #27 – None found for 1/2023 – 7/2023 *(Term of ISP 1/2023 – 1/2024.)* **Customized In-Home Supports Semi-Annual Reports:** • Individual #35 – None found for 2/2023 – 8/2023. *(Term of ISP 2/2023 – 2/2024.)* **Customized Community Supports Semi-Annual Reports:** • Individual #17 – None found for 12/2022 - 6/2023 *(Term of ISP 12/2022-12/2023.)* • Individual #28 – None found for 6/2022 - 11/2022 & 12/2022 - 1/2023 *(Term of ISP 6/2022 - 5/2024. ISP meeting held 2/9/2023).* • Individual #35 – None found for 2/2023 - 8/2023 *(Term of ISP 2/2023 - 2/2024.)* • Individual #53 – None found for 2/2023 - 8/2023 *(Term of ISP 2/2023 - 2/2024.)* **Community Integrated Employment Semi-Annual Reports:** • Individual #38 – None found 2/2023 – 7/2023. *(Term of ISP 2/2023 - 1/2024).*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

The 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: 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	**Nursing Semi - Annual Reports:** • Individual #17 – None found for 12/2022 - 6/2023. *(Term of ISP 12/2022-12/2023.)* • Individual #25 – None found for 11/2022 - 5/2023. *(Term of ISP 11/2022 - 11/2023).* • Individual #28 – None found for 6/2022 - 12/2022. *(Term of ISP 6/2022 - 5/2024).* • Individual #30 – None found for 10/2022 - 4/2023. *(Term of ISP 10/2022 - 10/2023).* • Individual #32 – None found for 1/2023 - 6/2023. *(Term of ISP 1/2023 - 1/2024).* • Individual #38 – None found for 2/2023 – 7/2023. *(Term of ISP 2/2023 - 1/2024).*		

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. 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.			

Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian) *(Modified by IRF)*	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;	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 19 of 52 Individuals: 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 #8: ISP was not provided to Individual. • Individual #19: ISP was not provided to Individual, Guardian, or IDT. • ~~Individual #31: ISP was not provided to Individual, Guardian, or IDT.~~ *(Removed by IRF Individual #31)* • Individual #33: ISP was not provided to Individual, Guardian, or IDT. • Individual #35: ISP was not provided to Individual. • Individual #40: ISP was not provided to Individual or Guardian. • Individual #45: ISP was not provided to IDT.	**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?)*: →	

(4) all other IDT members in attendance at the meeting to develop the ISP; (5) the individual's attorney, if applicable; (6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies; (7) for all developmental disabilities Medicaid waiver recipients, including *Jackson* class members, a copy of the completed ISP containing all the information specified in 7.26.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD; (8) for *Jackson* class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the *Jackson* lawsuit office of the DDSD. B. Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.	~~• Individual #50: ISP was not provided to Individual, Guardian, or IDT.~~ *(Removed by IRF Individual #50)* • Individual #53: ISP was not provided to Individual or Guardian. **Evidence indicated ISP was provided after 14-day window:** • Individual #1*: ISP effective date: 7/1/2023, ISP sent to Individual on 7/12/2023.* • Individual #3*: ISP effective date: 8/15/2023, ISP sent to Individual on 8/14/2023.* • Individual #7*: ISP effective date: 8/16/2023, ISP sent to Individual on 10/4/2023.* • Individual #9*: ISP effective date: 7/1/2023, ISP sent to Individual on 10/5/2023.* • Individual #10: *ISP effective date: 6/1/2023, ISP sent to Guardian and Individual on 5/31/2023.* • Individual #13: *ISP effective date: 6/1/2023, ISP sent to IDT on 7/17/2023.* • Individual #14: *ISP effective date: 1/10/2023, ISP sent to Individual or Guardian on 5/19/2023.* • Individual #22: *ISP effective date: 7/1/2023, ISP sent 7/14/2023.* • Individual #28: *ISP effective date: 6/1/2023, ISP sent 9/26/2023, and 10/5/2023*.		

	• Individual #41: *ISP effective date: 12/6/2022, ISP sent to Guardian on 10/3/2023.* • Individual #42: *ISP effective date: 1/1/2023, ISP sent to Guardian on 12/30/2022.* • Individual #45: *ISP effective date: 7/1/2023, ISP sent to Individual and Guardian on 7/11/2023.* • Individual #49: *ISP effective date: 4/21/2023, ISP sent to Guardian on 10/3/2023.*		

Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office) *(Modified by IRF)*	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;	Based on record review the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 24 of 52 Individuals: 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 #8 • Individual #19 • ~~Individual #21~~ • Individual #24 • ~~Individual #31~~ • Individual #32 • Individual #33 • Individual #35 • ~~Individual #50~~ *(Removed by IRF Individual #21, 31, 50)* **Evidence indicated ISP was provided after 14-day window:** • Individual #1*: ISP effective date: 7/1/2023, ISP sent to DDSD Regional Office on 7/12/2023.*	**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?)*: →	

(5) the individual's attorney, if applicable; (6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies; (7) for all developmental disabilities Medicaid waiver recipients, including *Jackson* class members, a copy of the completed ISP containing all the information specified in 7.26.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD; (8) for *Jackson* class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the *Jackson* lawsuit office of the DDSD. B. Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.	• Individual #7*: ISP effective date: 8/16/2023, ISP sent to DDSD Regional Office on 9/25/2023.* • Individual #9*: ISP effective date: 7/1/2023, ISP sent to DDSD Regional Office on 9/28/2023.* • Individual #10*: ISP effective date: 6/1/2023, ISP sent to DDSD Regional Office on 6/8/2023.* • Individual #13*: ISP effective date: 6/1/2023, ISP sent to DDSD Regional Office on 7/18/2023.* • Individual #14*: ISP effective date: 1/10/2023, ISP sent to DDSD Regional Office on 9/27/2023.* • Individual #16*: ISP effective date: 5/30/2023, ISP sent to DDSD Regional Office on 7/17/2023.* • Individual #17*: ISP effective date: 12/18/2022, ISP sent to DDSD Regional Office on 2/28/2023.* • Individual #18*: ISP effective date: 3/25/2023, ISP sent to DDSD Regional Office on 3/27/2023.* • Individual #22*: ISP effective date: 7/1/2023, ISP sent 7/14/2023.* • Individual #28*: ISP effective date: 6/1/2023, ISP sent to DDSD Regional Office on 10/4/2023.* • Individual #36: *ISP effective date: 12/2/2022, ISP sent to the DDSD Regional Office on 11/28/2022.*		

	• Individual #37*: ISP effective date: 7/3/2023, ISP sent to DDSD Regional Office on 9/25/2023.* • Individual #40*: ISP effective date: 6/1/2023, ISP sent to DDSD Regional Office on 6/21/2023.* • Individual #42*: ISP effective date: 1/1/2023, ISP sent to DDSD Regional Office on 12/30/2022.* • Individual #45*: ISP effective date: 7/1/2023, ISP sent to DDSD Regional Office on 7/18/2023.* • Individual #49*: ISP effective date: 4/21/2023, ISP sent to DDSD Regional Office on 6/8/2023.* • Individual #51*: ISP effective date: 11/12/2022, ISP sent to DDSD Regional Office on 9/26/2023.*		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Level of Care – *Initial and annual Level of Care (LOC) evaluations are completed within timeframes specified by the State.*			
Tag # 4C04 Assessment Activities ***(Modified by IRF)***	**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. **8.2.3 Facilitating Level of Care (LOC) Determinations and Other Assessment Activities:** The CM ensures that an initial evaluation for the LOC is complete, and that all participants are reevaluated for a LOC at least annually. CMs are also responsible for completing assessments related to LOC determinations and for obtaining other assessments to inform the service planning process. The assessment tasks of the CM include, but are not limited to: 1. Completing, compiling, and/or obtaining the elements of the Long-Term Care Assessment Abstract packet to include: a. a Long-Term Care Assessment Abstract form (MAD 378); b. Client Individual Assessment (CIA); c. a current History and Physical; d. a copy of the Allocation Letter (initial submission only); and e. for children, a norm-referenced assessment. 2. Timely submission of a completed LOC packet for review and approval by the TPA contractor including:	Based on record review, the Agency did not complete, compile, or obtain the elements of the Long-Term Care Assessment Abstract (LTCAA) packet and / or submitted the Level of Care in a timely manner, as required by standard for 2 of 52 individuals. Review of the Agency individual case files indicated the following items were not found, incomplete, and/or not current: **Annual Physical:** • Not Found (#40, ~~50~~) *(Removed by IRF Individual #50)* **~~Level of Care:~~** • ~~Not Current (#22)~~ *(Removed by IRF Individual #22)* **Client Individual Assessment (CIA):** • Not Current (#37)	**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?)***:** →	

a. responding to the TPA contractor within specified timelines when the Long- Term Care Assessment Abstract packet is returned for corrections or additional information; b. submitting complete packets, no later than 30 calendar days prior to the LOC expiration date for annual redeterminations; c. seeking assistance from the DDSD Regional Office related to any barriers to timely submission; and d. facilitating re-admission to the DD Waiver for people who have been hospitalized or who have received care in another institutional setting for more than three calendar days (upon the third midnight), which includes collaborating with the MCO Care Coordinator to resolve any problems with coordinating a safe discharge. 3. Obtaining assessments from DD Waiver Provider Agencies within the specified required timelines.			

Tag # 4C05 Review & Approval of the LTCAA by TPA *(Removed by IRF)*	Standard Level Deficiency		
~~Developmental Disabilities Waiver Service Standards Eff 11/1/2021~~ ~~**Chapter 1: Initial Allocation and Ongoing Eligibility: 1.7.1 Initial Allocation:** Once the Case Manager (CM) receives a copy of the PFOC, their responsibilities assisting and monitoring this process begin. In general, the CM is responsible for:…~~ ~~3. Compiling the Level of Care (LOC) packet which includes the LOC Abstract Form (MAD 378), History and Physical, completed by the applicant' s medical provider, as well as the Client Individual Assessment (CIA) completed by the CM.~~ ~~4. Submitting the LOC packet to the Medicaid TPA.~~ ~~5. Monitoring the status of the TPA approval of the LOC and responding to requests for information (RFIs) within required timeframes.~~ ~~6. Monitoring the applicant's eligibility status at ISD.~~ ~~**Chapter 8: Case Management: 8.2.2 Initial Allocation and Annual Recertification:** Although CMs are dependent on other DD Waiver Provider Agencies, upon people in services, and upon guardians to complete various activities, CMs have specific requirements to support and monitor a person's initial allocation and annual recertification. For Initial Allocations, the CM bills up to 20 hours (one time only) to facilitate the process for determining financial and medical eligibility within 90 calendar days of the date that the Case Management Provider Agency was selected. Chapter 1.7.~~	~~Based on record review, the Agency did not maintain documentation of Third-Party review and approval of Long-Term Care Assessment Abstract (LTCAA) for 1 of 52 individuals.~~ ~~The following items were not found, incomplete and/or not current:~~ ~~**Initial:** Level of Care:~~ ~~• Not Current (#22)~~ *(Removed by IRF Individual #22)*	**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?)*: →	

~~Medical and Financial Eligibility lists the CM requirements for this process.~~ **~~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.~~			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A22 / 4C02 Case Manager: Individual Specific Competencies	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 8: Case Management: 8.8 Scope:** DD Waiver CMs must have knowledge of the requirements for the entire system to effectively provide and monitor services. In general, the CM's scope of practice is to: 1. promote self-advocacy and advocate on behalf of the person; 2. facilitate and monitor the allocation and annual recertification processes as well as transitions as described in Section I Chapter 9 Transitions; 3. participate in specific assessment activities related to annual LOC determination and PCP; 4. link the person and guardian to publicly funded programs, community resources and non-disability specific resources available to all citizens and natural supports within the person's community; 5. organize and facilitate the PCP process and ISP development in accordance with the DD Waiver Service Standards as described in Chapter 4: Person-Centered Planning and Chapter 6: Individual Service Plan (ISP); 6. submit the ISP and the Waiver Budget Worksheet (BWS) and any other required documents to TPA Contractor(s), as outlined in Chapter 7: Available Services and Individual Budget Development; 7. monitor the ISP implementation including service delivery, coordination of other	Based on interview, the Agency did not ensure each case manager met the IST requirements in accordance with the specifications described in the ISP of each person supported for 3 of 28 Case Managers. **When the Case Managers were asked, to provide a general description of the Individual, including likes, dislikes, services, etc., the following was reported:** • #500 stated, "No allergies". The individual has an allergy to Seroquel (Individual #53). **When the Case Managers were asked, if the Individual had Assistive Technology or Adaptive Equipment, the following was reported:** • #509 stated, "G-tube, Wheelchair...I'm not sure what else... I couldn't find the AT inventory. I feel bad for saying but I don't know." According to agency file, the individual also uses: care seat, chair belt, grab bars, Hoyer lift, and shower chair. (Individual #25) • #500 stated, "wheelchair, hospital bed, grab bars, walker, Hoyer, iPad, shower chair, shower head, bidet." According to the agency file, the individual also uses: Arm Bicycle, Reacher, Rubber Jar Opener, Long Handled Sponge, Manageable Fire Extinguisher. (Individual #31)	**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?)***: →**	

supports, and health and safety assurances as described in the ISP; and 8. maintain a complete record for each person in services, as specified in Section II Chapter 20: Provider Documentation and Client Records and Appendix A Client File Matrix. **8.2.1 Promoting Self Advocacy and Advocating on Behalf of the Person in Services:** A primary role of the CM is to facilitate self-advocacy and advocate on behalf of the person, which includes, but is not limited to:… **8.3.1 CM Qualifications and Training Requirements:** 1. Within specified timelines, Case Management Provider Agencies must assure that all CMs meet the requirements for pre-service and core competency and ongoing annual training as specified in the Section II Chapter 17: Training Requirements. 2. Case Management Provider Agencies must have professional development requirements in place to assure that all CMs engage in continuing education, DDSD trainings, professional skill building activities, and remediate any performance issues. 3. Case Management Provider Agencies and their staff/sub-contractors must adhere to all requirements communicated to them by DDSD, including participation in the Therap system, attendance at mandatory meetings and trainings, and participation in technical assistance sessions. 4. Case Management Provider Agencies and their staff/subcontractors must adhere to all training requirements to use secure and web-based systems to transfer information as required by the TPA. (This includes the	**When the Case Managers were asked, if the Individual had Healthcare Plans the following was reported:** • #511 stated, "Constipation, Rosacea/Skin Integrity, oral care/hygiene." According to Electronic Comprehensive Health Assessment Tool, the individual does not have a HCP for skin integrity however, per eCHAT the Individual has an additional HCP for Falls. (Individual #24) **When the Case Managers were asked, if the Individual had Medical Emergency Response Plans, the following was reported:** • #511 stated, "Constipation." According to the Electronic Comprehensive Health Assessment Tool**,** does not have a MERP for constipation, however, per eCHAT the Individual has an additional MERP for Falls. (Individual #24)		

TPA Web Portal and Secure CISCO system). 5. The CM Code of Ethics must be followed by all CMs employed by or subcontracting with the agency and supporting documentation must be placed in CM personnel files. 6. CMs, whether subcontracting or employed by a Provider Agency, shall meet the following requirements, and possess the following qualifications: a. be a licensed social worker, as defined by the NM Board of Social Work Examiners; or b. be a licensed registered nurse as defined by the NM Board of Nursing; or c. have a Bachelor's or Master's degree in social work, psychology, counseling, nursing, special education, or closely related field; and d. have one-year clinical experience, related to the target population, working in any of the following settings: i. home health or community health program, ii. hospital, iii. private practice, iv. publicly funded institution or long-term care program, v. mental health program, vi. community based social service program, or vii. other programs addressing the needs of special populations, e.g., school. e. or have a minimum of 6 years of direct experience related to the delivery of social services to people with disabilities. 7. CMs, whether subcontracting or employed by a Provider Agency, shall have			

a working knowledge of the health and social resources available within a region. **Chapter 17: Training Requirements: 17.2 Training Requirements for CMs and Case Management Supervisors** 1. CMs must successfully: a. complete IST requirements in accordance with the specifications described in the ISP of each person supported; b. complete training regarding the HIPAA located in the New Mexico Waiver Training Hub; 2. CM and CM Supervisors shall also complete DDSD-approved core curriculum training facilitated by certified trainers and mentors which includes: **a.** Complete ANE (Abuse, Neglect and Exploitation) Awareness training within 30 calendar days of hire and prior to working alone with a person in services, then complete ANE Awareness every year; …			

Tag # 1A26 Employee Abuse Registry *(Modified by IRF)*	Standard Level Deficiency		
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search	Based on record review, the Agency did not maintain documentation in the employees' personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 2 of 28 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** • ~~#514 – Date of hire 7/1/2023, completed 8/22/2023.~~ *(Removed by IRF CM #514)* • #523 – Date of hire 12/15/2021, completed 4/26/2022.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.			

Tag # 1A26.1 Employee Abuse Registry *(Remove by IRF)*	~~Condition of Participation Level Deficiency~~		
~~**NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.~~ ~~A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.~~ ~~B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.~~ ~~C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search~~	~~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 documentation in the employees' personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 2 of 28 Agency Personnel.~~ ~~**The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:**~~ ~~• #519 – Date of hire 5/1/2023.~~ ~~• #527 – Date of hire 5/1/2023.~~ *(Removed by IRF Case Managers #519 and 527)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

~~the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry.~~ ~~D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.~~ ~~E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.~~ ~~F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.~~			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 4C17.1 Case Manager Qualifications: Credentials *(Removed by IRF)*	**Standard Level Deficiency**		
~~Developmental Disabilities Waiver Service Standards Eff 11/1/2021~~ ~~**Chapter 8 : Case Management: 8.3.1 CM Qualifications and Training Requirements:**~~ ~~1. Within specified timelines, Case Management Provider Agencies must assure that all CMs meet the requirements for pre-service and core competency and ongoing annual training as specified in the Section II Chapter 17: Training Requirements.~~ ~~2. Case Management Provider Agencies must have professional development requirements in place to assure that all CMs engage in continuing education, DDSD trainings, professional skill building activities, and remediate any performance issues.~~ ~~3. Case Management Provider Agencies and their staff/sub-contractors must adhere to all requirements communicated to them by DDSD, including participation in the Therap system, attendance at mandatory meetings and trainings, and participation in technical assistance sessions.~~ ~~4. Case Management Provider Agencies and their staff/subcontractors must adhere to all training requirements to use secure and web-based systems to transfer information as required by the TPA. (This includes the TPA Web Portal and Secure CISCO system).~~ ~~5. The CM Code of Ethics must be followed by all CMs employed by or subcontracting with the agency and supporting~~	~~Based on record review, the Agency did not ensure Case Managers met the credentials and / or code of ethic requirements for 1 of 28 Case Managers.~~ ~~**Review of Case Manager personnel records found no evidence of the following:**~~ ~~• Case Manager Code of Ethics (#506)~~ *(Removed by IRF Case Manager #506)*	**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?)*: →	

documentation must be placed in CM personnel files. 6. CMs, whether subcontracting or employed by a Provider Agency, shall meet the following requirements, and possess the following qualifications: a. be a licensed social worker, as defined by the NM Board of Social Work Examiners; or b. be a licensed registered nurse as defined by the NM Board of Nursing; or c. have a Bachelor's or Master's degree in social work, psychology, counseling, nursing, special education, or closely related field; and d. have one-year clinical experience, related to the target population, working in any of the following settings: i. home health or community health program, ii. hospital, iii. private practice, iv. publicly funded institution or long-term care program, v. mental health program, vi. community based social service program, or vii. other programs addressing the needs of special populations, e.g., school. e. or have a minimum of 6 years of direct experience related to the delivery of social services to people with disabilities. 7. CMs, whether subcontracting or employed by a Provider Agency, shall have a working knowledge of the health and social resources available within a region.			

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Completion Date
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Standard Level Deficiency**		
Developmental Disabilities 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: 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	Based on record review, the Agency did not maintain a complete client record at the administrative office for 1 of 52 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: **Nutritional Evaluation** • Individual #39 - As indicated by the documentation reviewed, the evaluation is applicable to the Individual. No documented evidence of the exam being completed was found.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

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. 13. 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. 14. 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. 15. 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. 17. 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. 18. 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. **Chapter 20: 20.5.4 *Health Passport and Physician Consultation Form:*** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form generated from an e-CHAT in the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. Requirements for the *Health Passport* and *Physician Consultation* form are: 1. The Case Manager and Primary and Secondary Provider Agencies must communicate critical information to each other and will keep all required sections of Therap updated in order to have a current and thorough *Health Passport* and *Physician Consultation* Form available at all times. Required sections of Therap include the IDF, Diagnoses, and Medication History.			

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	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.
	Based on record review, the Agency did not maintain a complete client record at the administrative office for 6 of 52 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 (#24)
	
	Aspiration Risk Screening Tool (ARST):
	• Not Found (#27)
	
	Comprehensive Aspiration Risk Management Plan*:*
	• Not Current (#52)
	
	Health Care Plans:
	• *Constipation*
	  • Individual #47- As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found.
	
	• *Oxygen*
	  • Individual #38 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found.
	
	Medical Emergency Response Plans:
	• *Aspiration*
	  • Individual #26 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found.
	
	• *Reflux*
		Provider:
		State your Plan of Correction for the deficiencies cited in this tag here *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: →
		
		Provider:
		Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

	• Individual #26 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of plan found.		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag #1A12 All Services Reimbursement	**No Deficient Practices Found**		
NMAC 8.302.2 BILLING FOR MEDICAID SERVICES Developmental Disabilities Waiver Service Standards Eff 11/1/2021 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 3. Details of the services provided. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer.	Based on record review, the Agency maintained all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving case management for 52 of 52 individuals. *Progress notes and billing records supported billing activities for the months of June, July, and August 2023.*		

4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date: a. treatment or care of any eligible recipient; b. services or goods provided to any eligible recipient; c. amounts paid by MAD on behalf of any eligible recipient; and d. any records required by MAD for the administration of Medicaid. **21.7 Billable Activities**: Specific billable activities are defined in the scope of work and service requirements for each DD Waiver service. In addition, any billable activity must also be consistent with the person's approved ISP. **21.9 Billable Units**: The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit, or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days. 2. Face-to-face billable services shall be provided during a month where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit.			

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date: January 18, 2024

To: Melinda Broussard, Executive Director / Case Manager

Provider: A Step Above Case Management, Corporation
Address: 2716 San Pedro NE, Ste. A
State/Zip: Albuquerque, New Mexico 87110

E-mail Address: jelliebeans6869@gmail.com

Region: Metro, Northeast, Northwest, Southwest
Survey Date: September 25 – October 11, 2023

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Case Management

Survey Type: Routine

Dear Ms. Broussard:

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.FY24.Q1.DDW.79006817.1/2/3/5.RTN.09.23.018