

Reviewed by IRF 6/18/2019

Date: May 17, 2019

To: Andrea Gonzales, Executive Director / Case Manager
Provider: A New Vision Case Management Inc.
Address: 3949 Corrales Road, Suite 115
City, State, Zip: Corrales, New Mexico 87048

E-mail Address: bluebirdcm@outlook.com

Region: Metro
Survey Date: April 26 – May 2, 2019

Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: **2007, 2012 & 2018**: Case Management

Survey Type: Routine

Team Leader: Kayla Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Member: Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Crystal Lopez-Beck, BA, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau, Elisa Alford, MSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Heather Driscoll, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Monica deHerrera-Pardo, LBSW, MCJ, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mrs. Gonzales;

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.

DIVISION OF HEALTH IMPROVEMENT
5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
(505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>



QMB Report of Findings – A New Vision Case Management, Inc. – Metro – April 26 – May 2, 2019

Survey Report #: Q.19.4.DDW.D3715.5.RTN.01.19.137

The following tags are identified as Condition of Participation Level:

- Tag # 4C07 Individual Service Planning (Visions, measurable outcome, action steps)

The following tags are identified as Standard Level:

- Tag # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components
- Tag # 4C12 Monitoring & Evaluation of Services
- Tag # 4C15.1 Service Monitoring: Annual / Semi-Annual Reports & Provider Semi-Annual / Quarterly Report
- Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)
- Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDS Office)
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)
- Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider
- Tag # 4C21 Case Management Reimbursement

Plan of Correction:

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

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

Corrective Action for Current Citation:

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

On-going Quality Assurance/Quality Improvement Processes:

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

Submission of your Plan of Correction:

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

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

- 1. Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator
1170 North Solano Suite D Las Cruces, New Mexico 88001**
- 2. Developmental Disabilities Supports Division Regional Office for region of service surveyed**

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as

soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

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

Billing Deficiencies:

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

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

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

Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)
OR
Jennifer Goble (Jennifer.goble2@state.nm.us)

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

Request for Informal Reconsideration of Findings (IRF):

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

Request for Informal Reconsideration of Findings
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request/QMB

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

Please call the Plan of Correction Coordinator Amanda Castaneda at 575-373-5716 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,

Kayla Benally, BSW

Kayla Benally, BSW

Survey Process Employed:

Administrative Review Start Date:	April 26, 2019
Contact:	<u>A New Vision Case Management, Inc.</u> Andrea Gonzales, Executive Director / Case Manager <u>DOH/DHI/QMB</u> Crystal Lopez-Beck, BA, Deputy Bureau Chief
On-site Entrance Conference Date:	April 29, 2019
Present:	<u>A New Vision Case Management, Inc.</u> Andrea Gonzales, Executive Director / Case Manager Tammy Evans, Case Manager Josie Pflieger, Case Manager Sharon Kirkman, Case Manager <u>DOH/DHI/QMB</u> Kayla Benally, BSW, Team Lead/Healthcare Surveyor Crystal Lopez-Beck, BA, Deputy Bureau Chief Lora Norby, Healthcare Surveyor Elisa Alford, MSW, Healthcare Surveyor Heather Driscoll, AA, Healthcare Surveyor
Exit Conference Date:	May 2, 2019
Present:	<u>A New Vision Case Management, Inc.</u> Andrea Gonzales, Executive Director / Case Manager <u>DOH/DHI/QMB</u> Kayla Benally, BSW, Team Lead/Healthcare Surveyor Crystal Lopez-Beck, BA, Deputy Bureau Chief Elisa Alford, MSW, Healthcare Surveyor <u>DDSD - Metro Regional Office</u> Michelle Flores, Case Manager Coordinator
Administrative Locations Visited	1
Total Sample Size	30 3 - <i>Jackson</i> Class Members 27 - <i>Non-Jackson</i> Class Members
Persons Served Records Reviewed	30
Case Manager Interviewed	12
Case Manager Records Reviewed	12 (<i>Executive Director also performs duties as a Case Manager</i>)

Total # of Secondary Freedom of Choices 138

Administrative Interviews 1 (*Executive Director also performs duties as a Case Manager*)

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
 - Individual Service Plans
 - Progress on Identified Outcomes
 - Healthcare Plans
 - Medication Administration Records
 - 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
- Human Rights Committee Notes and Meeting Minutes
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
NM Attorney General's Office

Attachment A

Provider Instructions for Completing the QMB Plan of Correction (POC) Process

Introduction:

After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued deficiencies and non-compliance.

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the DDS 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 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. Requests for technical assistance must be requested through your Regional DDS 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, Amanda Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
 - a. Electronically at AmandaE.Castaneda@state.nm.us (**preferred method**)
 - b. Fax to 575-528-5019, or
 - c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001
5. **Do not submit supporting documentation** (evidence of compliance) to QMB **until after** your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”
 - a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45-business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
 - b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.
 - c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.

- d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
 - e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a maximum of 45-business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If documents containing HIPAA Protected Health Information (PHI) documents must be submitted through S-Comm (Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may submit your documents electronically scanned and attached to e-mails.
3. All submitted documents must be annotated; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the 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 DDS 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 (DDS), 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 Case Management are as follows:

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.*

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

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- **4C10** – Apprv. Budget Worksheet Waiver Review Form / MAD 046
- **4C12** – Monitoring & Evaluation of Services
- **4C16** – Requirements for Reports & Distribution of ISP (Provider Agencies, Individual and/or Guardian)

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

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

- **4C04** – Assessment Activities

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

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

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

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

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

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

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

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

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

- **1A05** – General Requirements

Attachment C

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

Introduction:

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

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: <https://nmhealth.org/about/dhi/cbp/irf/>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Crystal Lopez-Beck at Crystal.Lopez-Beck@state.nm.us for assistance.

The following limitations apply to the IRF process:

- The written request for an IRF and all supporting evidence must be received within 10 business days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.
- Providers may not request an IRF to challenge the DHI/QMB determination of compliance or the length of their DDSD provider contract.

A Provider forfeits the right to an IRF if the request is not received within 10 business days of receiving the report and/or does not include all supporting documentation or evidence to show compliance with the standards and regulations.

The IRF Committee will review the request; the Provider will be notified in writing of the ruling; no face-to-face meeting will be conducted.

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.

Attachment D

QMB Determinations of Compliance

Compliance:

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

Partial-Compliance with Standard Level Tags:

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

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.
2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

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

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

Non-Compliance:

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

1. Your Report of Findings includes 17 or more Standard Level Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any 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	
Standard Level 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 CoPs	0 to 5 CoPs	6 or more CoPs
	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 Standard Level Tags with 75 to 100% of the Individuals in the sample cited in any 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 of 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 New Vision Case Management Inc. – Metro Region
Program: Developmental Disabilities Waiver
Service: 2007, 2012 & 2018: Case Management
Survey Type: Routine
Survey Date: April 26 – May 2, 2019

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p><i>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.</i></p>			
<p>Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components</p>	<p>Standard Level Deficiency</p>		
<p>NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY.</p> <p>NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS.</p> <p>NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS. Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record: The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix.</p> <p>Chapter 6 Individual Service Plan: The CMS requires a person-centered service plan for every person receiving HCBS. The DD Waiver's person-centered service plan is the ISP.</p> <p>6.5.2 ISP Revisions: The ISP is a dynamic document that changes with the person's</p>	<p>Based on record review, the Agency did not maintain a complete client record at the administrative office for 2 of 30 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p>ISP Signature Page:</p> <ul style="list-style-type: none"> Not Fully Constituted IDT (No evidence of Nurse and SLP involvement) (#30) <p>ISP Teaching & Support Strategies:</p> <p>Individual #1: <i>TSS not found for Live Outcome Statement / Action Steps:</i></p> <ul style="list-style-type: none"> "...will request one item." 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(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> →</p>	<p> </p>

desires, circumstances, and need. IDT members must collaborate and request an IDT meeting from the CM when a need to modify the ISP arises. The CM convenes the IDT within ten days of receipt of any reasonable request to convene the team, either in person or through teleconference.

6.6 DDSD ISP Template: The ISP must be written according to templates provided by the DDSD. Both children and adults have designated ISP templates. The ISP template includes Vision Statements, Desired Outcomes, a meeting participant signature page, an Addendum A (i.e. an acknowledgement of receipt of specific information) and other elements depending on the age of the individual. The ISP templates may be revised and reissued by DDSD to incorporate initiatives that improve person - centered planning practices. Companion documents may also be issued by DDSD and be required for use in order to better demonstrate required elements of the PCP process and ISP development.

The ISP is completed by the CM with the IDT input and must be completed according to the following requirements:

1. DD Waiver Provider Agencies should not recommend service type, frequency, and amount (except for required case management services) on an individual budget prior to the Vision Statement and Desired Outcomes being developed.
2. The person does not require IDT agreement/approval regarding his/her dreams, aspirations, and desired long-term outcomes.
3. When there is disagreement, the IDT is required to plan and resolve conflicts in a manner that promotes health, safety, and quality of life through consensus. Consensus means a state of general agreement that allows members to support the proposal, at least on a trial basis.

<p>4. A signature page and/or documentation of participation by phone must be completed.</p> <p>5. The CM must review a current Addendum A and DHI ANE letter with the person and Court appointed guardian or parents of a minor, if applicable.</p> <p>6.7 Completion and Distribution of the ISP: The CM is required to assure all elements of the ISP and companion documents are completed and distributed to the IDT...</p> <p>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.</p>			
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Tag # 4C07 Individual Service Planning (Visions, measurable outcomes, action steps)	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 4: Person-Centered Planning (PCP): 4.1 Essential Elements of Person-Centered Planning (PCP): Person-centered planning is a process that places a person at the center of planning his/her life and supports. It is an ongoing process that is the foundation for all aspects of the DD Waiver Program and DD Waiver Provider Agencies' work with people with I/DD. The process is designed to identify the strengths, capacities, preferences, and needs of the person. The process may include other people chosen by the person, who are able to serve as important contributors to the process. Overall, PCP involves person-centered thinking, person-centered service planning, and person-centered practice. PCP enables and assists the person to identify and access a personalized mix of paid and non-paid services and supports to assist him or her to achieve personally defined outcomes in the community. The CMS requires use of PCP in the development of the ISP.</p> <p>NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS: Each ISP shall contain.</p> <p>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.</p> <p>C. Outcomes:</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not ensure Case Managers developed realistic and measurable desired outcomes for the individual as identified in the ISP which includes the individual's long-term vision, summary of strengths, preferences and needs, desired outcomes and an action plan for 7 of 30 Individuals.</p> <p>The following was found regarding the ISP:</p> <p>Individual #1</p> <ul style="list-style-type: none"> • Vision for Live Outcome: "The IDT agrees if ... could communicate his vision he would say, I want to remain in my current home with my family/guardian where I feel most comfortable and safe, and all my needs met." "I want to do more activities when I'm home." Outcome indicates, "With assistance ... will utilize his eye gaze technology 1 - 2 times a month for 6 months." Action step indicates, "will request one item." Review of ISP found outcome and action step do not related to the vision. <p>Individual #2:</p> <ul style="list-style-type: none"> • Work/Education/Volunteer Outcome: "...will participate in a group activity with a minimum of 3 prompts." Outcome does not indicate how and/or when it would be completed. <p>Individual #3:</p> <ul style="list-style-type: none"> • Live Outcome: "...will work on money management skills." Outcome does not indicate how and/or when it would be completed. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(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> →</p>	

<p>(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.</p> <p>(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.</p> <p>D. Individual preference: The individual's preferences, capabilities, strengths and needs in each life area determined to be relevant to the identified ISP outcomes shall be reflected in the ISP. The long term vision, age, circumstances, and interests of the individual, shall determine the life area relevance, if any to the individual's ISP.</p> <p>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</p>	<p>Individual #14:</p> <ul style="list-style-type: none"> • Live Outcome: "...will work on tracking his money with his FLP." Outcome does not indicate how and/or when it would be completed. • Health Outcome: "...will participate in a physical activity." Outcome does not indicate how and/or when it would be completed. <p>Individual #15:</p> <ul style="list-style-type: none"> • Live Outcome: "...will utilize his picture symbols to choose what he would like to grill, monthly." Outcome was does not indicate how and/or when it would be completed. <p>Individual #21:</p> <ul style="list-style-type: none"> • Live Outcome: "I want to complete kitchen tasks independently." Outcome was does not indicate how and/or when it would be completed. <p>Individual #22:</p> <ul style="list-style-type: none"> • Live Outcome: "...will demonstrate the ability to care for himself." Outcome was does not indicate how and/or when it would be completed. 		
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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.

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Tag # 4C12 Monitoring and Evaluation of Services <i>(Upheld by IRF)</i>	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record: The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix.</p> <p>8.2.7 Monitoring and Evaluating Service Delivery: The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health and safety of the person. Monitoring and evaluation activities include the following requirements: 1. The CM is required to meet face-to-face with adult DD Waiver participants at least 12 times annually (one time per month) to bill for a monthly unit. 2. JCMs require two face-to-face contacts per month to bill the monthly unit, one of which must occur at a location in which the person spends the majority of the day (i.e., place of employment, habilitation program), and the other contact must occur at the person's residence. 3. Parents of children on the DD Waiver must receive a minimum of four visits per year, as established in the ISP. The parent is responsible for monitoring and evaluating services provided in the months case management services are not received. 4. No more than one IDT Meeting per quarter may count as a face-to-face contact for adults (including JCMs) living in the community. 5. For non-JCMs, face-to-face visits must occur</p>	<p>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 2 of 30 individuals.</p> <p>Review of the Agency Individual case-files revealed face-to-face visits were not being completed as required by standards (#2, #5, a, b, and c) for the following individuals:</p> <p>Individual #23 (Non-Jackson) No home visits were noted between 11/2018 – 2/2019.</p> <ul style="list-style-type: none"> • 11/29/2018 – 11:30 am-12:30 pm - Site Visit • 12/04/2018 – 10:00 am-11:00 am - Site Visit • 1/08/2019 – 10:00 am-12:00 pm – Site Visit • 2/28/2019 – 10:45 am-11:00 am – Site Visit <p>Review of the Agency individual case files revealed no evidence indicating face-to-face visits were completed as required for the following individuals:</p> <ul style="list-style-type: none"> • Individual #15 - No Face to Face Visit Summary Forms found for February and March 2019. Per contact notes visit occurred on 2/27/2019, 3/26/2019, and 3/27/2019. <p><i>Note: Findings for Individual #23 and Individual #15 upheld by IRF on 6/18/2019.</i></p>	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(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> →</p>	<p> </p>

as follows:

- a. At least one face-to-face visit per quarter shall occur at the person's home for people who receive a Living Supports or CIHS.
- b. At least one face-to-face visit per quarter shall occur at the day program for people who receive CCS and or CIE in an agency operated facility.
- c. It is appropriate to conduct face-to-face visits with the person either during times when the person is receiving a service or during times when the person is not receiving a service.
- d. The CM considers preferences of the person when scheduling face-to face-visits in advance.
- e. Face-to-face visits may be unannounced depending on the purpose of the monitoring.
- 6. The CM must monitor at least quarterly:
 - a. that applicable MERPs and/or BCIPs are in place in the residence and at the day services location(s) for those who have chronic medical condition(s) with potential for life threatening complications, or for individuals with behavioral challenge(s) that pose a potential for harm to themselves or others; and
 - b. that all applicable current HCPs (including applicable CARMP), PBSP or other applicable behavioral plans (such as PPMP or RMP), and WDSIs are in place in the applicable service sites.
- 7. When risk of significant harm is identified, the CM follows. the standards outlined in Chapter 18: Incident Management System.
- 8. The CM must report all suspected ANE as required by New Mexico Statutes and complete all follow up activities as detailed in Chapter 18: Incident Management System.
- 9. If concerns regarding the health or safety of the person are documented during monitoring or assessment activities, the CM immediately notifies appropriate supervisory personnel within the DD Waiver Provider Agency and documents the concern. In situations where the concern is not urgent, the DD Waiver Provider Agency is

allowed up to 15 business days to remediate or develop an acceptable plan of remediation.

10. If the CMs reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed upon period of time, the CM shall use the RORA process detailed in Chapter 19: Provider Reporting Requirements.

11. The CM conducts an online review in the Therap system to ensure that the e-CHAT and Health Passport are current: quarterly and after each hospitalization or major health event.

14. The CM will ensure Living Supports, CIHS, CCS, and CIE are delivered in accordance with CMS Setting Requirements described in Chapter 2.1 CMS Final Rule: Home and Community-Based Services (HCBS) Settings Requirements. If additional support is needed, the CM notifies the DDS Regional Office through the RORA process.

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015
**CHAPTER 4 (CMgt) 2. Service Requirements:
D. Monitoring And Evaluation of Service Delivery:**

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007
**CHAPTER 4 III. CASE MANAGEMENT
SERVICE REQUIREMENTS: J. Case Manager
Monitoring and Evaluation of Service Delivery**

Tag # 4C15.1 Service Monitoring - Annual / Semi-Annual Reports & Provider Semi - Annual / Quarterly Reports	Standard Level Deficiency		
<p>7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:</p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record: The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix.</p> <p>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</p>	<p>Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 1 of 30 individuals.</p> <p>Review of the Agency individual case files revealed no evidence of quarterly/bi-annual reports for the following:</p> <p>Customized Community Supports Semi-Annual Reports:</p> <ul style="list-style-type: none"> Individual 9 – None found for November 2017- April 2018. (Term of ISP 11/01/2017- 10/31/2018.) 	<p>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?): →</p> <p>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?): →</p>	<p> </p>

<p>responsible for monitoring the health and safety of the person...</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</p> <p>CHAPTER 4 (CMgt) 2. Service Requirements:</p> <p>C. Individual Service Planning:</p> <p>D. Monitoring And Evaluation of Service Delivery:</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</p> <p>C. Quality Assurance Requirements:</p>			
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Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)	Standard Level Deficiency		
<p>NMAC 7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:</p> <p>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:</p> <ol style="list-style-type: none"> (1) the individual; (2) the guardian (if applicable); (3) all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons; (4) all other IDT members in attendance at the meeting to develop the ISP; (5) the individual's attorney, if applicable; (6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies; (7) for all developmental disabilities Medicaid waiver recipients, including <i>Jackson</i> 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 <i>Jackson</i> class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the <i>Jackson</i> lawsuit office of the DDSD. <p>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.</p>	<p>Based on record review and/or interview the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 4 of 30 Individual:</p> <p>The following was found indicating the agency failed to provide a copy of the ISP within 14 days of the ISP Approval to the Provider Agencies, Individual and / or Guardian:</p> <p>No Evidence found indicating ISP was distributed:</p> <ul style="list-style-type: none"> • Individual #28: ISP was not provided to Supported Living Services, CCS-G, CCS-SG, SLP, BSC, OT, and PT. • Individual #30: ISP was not provided to Family Living Services, CIES, PT, SLP, OT and Guardian. <p>Evidence indicated ISP was provided after 14-day window:</p> <ul style="list-style-type: none"> • Individual #10: <i>ISP approval date was 2/27/2019, ISP was sent to Guardian on 4/30/2019.</i> • Individual 20: <i>ISP approval date was 5/2/2018, ISP was sent to Guardian on 7/27/2018.</i> 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(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> →</p>	<p> </p>

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019

Chapter 6 Individual Service Plan (ISP) 6.7 Completion and Distribution of the ISP: The CM is required to assure all elements of the ISP and companion documents are completed and distributed to the IDT. However, DD Waiver Provider Agencies share responsibility to contribute to the completion of the ISP. The ISP must be completed and approved prior to the expiration date of the previous ISP term. Within 14 days of the approved ISP and when available, the CM distributes the ISP to the DDSD Regional Office, the DD Waiver Provider Agencies with a SFOC, and to all IDT members requested by the person.

Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)	Standard Level Deficiency		
<p>NMAC 7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:</p> <p>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:</p> <ol style="list-style-type: none"> (1) the individual; (2) the guardian (if applicable); (3) all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons; (4) all other IDT members in attendance at the meeting to develop the ISP; (5) the individual's attorney, if applicable; (6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies; (7) for all developmental disabilities Medicaid waiver recipients, including <i>Jackson</i> 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 <i>Jackson</i> class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the <i>Jackson</i> lawsuit office of the DDSD. <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff</p>	<p>Based on record review and/or interview the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 5 of 30 Individual:</p> <p>The following was found indicating the agency failed to provide a copy of the ISP within 14 days of the ISP Approval to the respective DDSD Regional Office:</p> <p>No Evidence found indicating ISP was distributed:</p> <ul style="list-style-type: none"> • Individual #25 • Individual #30 <p>Evidence indicated ISP was provided after 14-day window:</p> <ul style="list-style-type: none"> • Individual #1: <i>ISP approval date was 2/7/2019, ISP was sent to DDSD Regional Office on 04/23/2019.</i> • Individual #10: <i>ISP approval date was 2/27/2019, ISP was sent to the DDSD Regional Office on 4/29/2019.</i> • Individual 13: <i>ISP approval date was 6/25/2018, ISP was sent to the DDSD Regional Office on 9/18/2018.</i> 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here (<i>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?</i>): →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (<i>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>): →</p>	<p> </p>

<p>1/1/2019</p> <p>Chapter 6 Individual Service Plan (ISP) 6.7 Completion and Distribution of the ISP: The CM is required to assure all elements of the ISP and companion documents are completed and distributed to the IDT. However, DD Waiver Provider Agencies share responsibility to contribute to the completion of the ISP. The ISP must be completed and approved prior to the expiration date of the previous ISP term. Within 14 days of the approved ISP and when available, the CM distributes the ISP to the DDSD Regional Office, the DD Waiver Provider Agencies with a SFOC, and to all IDT members requested by the person.</p>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Health, Safety 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		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record: The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix.</p> <p>Chapter 3 Safeguards: 3.1.1 Decision Consultation Process (DCP): Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: 1.The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have</p>	<p>Based on record review, the Agency did not maintain a complete client record at the administrative office for 2 of 30 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p>Dental Exam</p> <ul style="list-style-type: none"> Individual #15 - As indicated by the documentation reviewed, exam was completed on 3/15/2018. Follow-up was to be completed in 1 year. No documented evidence of the follow-up being completed was found. (Note: Exam scheduled on 6/25/2019) Individual #25 - As indicated by the documentation reviewed, exam was scheduled for 3/25/2019. No documented evidence was found to verify exam was completed. (Note: Exam scheduled for 6/22/2019) 	<p>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?): →</p> <p>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?): →</p>	<p> </p>

<p>performed an evaluation such as a video-fluoroscopy;</p> <p>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and</p> <p>d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.</p> <p>2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting:</p> <p>a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation.</p> <p>b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation.</p> <p>c. Providers support the person/guardian to make an informed decision.</p> <p>d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.</p> <p>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</p>			
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information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.

DD Waiver Provider Agencies are required to adhere to the following:

1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.
2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable.
3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.
4. Provider Agencies must maintain records 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.

1. 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.
2. 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.
3. 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

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<p>agreement, or upon provider withdrawal from services.</p> <p>20.5.3 Health Passport and Physician Consultation Form: All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form. The Physician Consultation form contains a list of all current medications. Requirements for the Health Passport and Physician Consultation form are:</p> <p>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.</p>			
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Tag # 1A15.2 Administrative Case File - Healthcare Documentation (Therap and Required Plans)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 8 Case Management: 8.2.8 Maintaining a Complete Client Record: The CM is required to maintain documentation for each person supported according to the following requirements: 3. The case file must contain the documents identified in Appendix A Client File Matrix.</p> <p>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p>	<p>Based on record review, the Agency did not maintain a complete client record at the administrative office for 3 of 30 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p>Electronic Comprehensive Health Assessment Tool:</p> <ul style="list-style-type: none"> • Not Found (#26) <p>Electronic Comprehensive Health Assessment Tool Summary:</p> <ul style="list-style-type: none"> • Not Found (#26) <p>Aspiration Risk Screening Tool:</p> <ul style="list-style-type: none"> • Not Found (#26) <p>Medical Emergency Response Plans:</p> <ul style="list-style-type: none"> • <i>Colonized/Infected with Multidrug Resistance Organisms</i> <ul style="list-style-type: none"> • Individual #1 - As indicated by the eCHAT the individual is required to have a plan. No evidence of plan found. • <i>Endocrine</i> <ul style="list-style-type: none"> • Individual #9 - As indicated by the eCHAT the individual is required to have a plan. Plan was not signed or dated. • <i>Falls</i> <ul style="list-style-type: none"> • Individual #9 - As indicated by the eCHAT the individual is required to have a plan. Plan was not signed or dated. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(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> →</p>	<p> </p>

<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Chapter 3 Safeguards: 3.1.1 Decision Consultation Process (DCP): Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following:</p> <p>1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to:</p>			
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<p>a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;</p> <p>b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy;</p> <p>c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and</p> <p>d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan.</p> <p>2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting:</p> <p>a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation.</p> <p>b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation.</p> <p>c. Providers support the person/guardian to make an informed decision.</p> <p>d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health</p>			
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decision in every setting.

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015

CHAPTER 4 (CMgt) I. Case Management

Services: 1. Scope of Services: S. Maintain a complete record for the individual's DDW services, as specified in DDS Consumer Records Requirements Policy;

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007

CHAPTER 1 II. PROVIDER AGENCY

REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.

D. Provider Agency Case File for the

Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:

(1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if

<p>appropriate;</p> <p>(2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>			
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Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider	Standard Level Deficiency		
<p>NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:</p> <p>A. Duty to report:</p> <p>(1) All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers.</p> <p>(2) All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety.</p> <p>B. Reporter requirement. All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident.</p> <p>C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:</p> <p>(1) Abuse, neglect, and exploitation, suspicious injury or death reporting: Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or</p>	<p>Based on record review, the Agency did not report suspected abuse, neglect, or exploitation, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 2 of 30 Individuals.</p> <p>During the on-site survey 4/29 - 5/2, 2019, surveyors found evidence of 2 internal agency incident reports, which had not been reported to DHI, as required by regulation.</p> <p>The following internal incidents were reported as a result of the on-site survey:</p> <p>Individual #1</p> <ul style="list-style-type: none"> Incident date prior to 2/18/2019. Type of incident identified was abuse. Incident was brought to the attention of the Agency by Surveyors. ANE report was filed on 4/29/2019 by DHI/QMB. <p>Individual #30</p> <ul style="list-style-type: none"> Incident date prior to 3/25/2019. Type of incident identified was neglect. Incident was brought to the attention of the Agency by Surveyors. ANE report was filed on 4/30/2019 by DHI/QMB. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here <i>(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</i> →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here <i>(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> →</p>	

report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, <http://dhi.health.state.nm.us>, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242.

(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers: In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at <http://dhi.health.state.nm.us>; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form.

(3) Limited provider investigation: No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation.

(4) Immediate action and safety planning: Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based

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

(8) Non-responsible reporter: Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain: Medicaid Billing/Reimbursement - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.			
Tag # 4C21 Case Management Reimbursement (Upheld by IRF)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p>Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:</p> <p>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:</p> <p>4. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing.</p> <p>5. Comprehensive documentation of direct service delivery must include, at a minimum:</p> <ol style="list-style-type: none"> the agency name; the name of the recipient of the service; the location of the service; the date of the service; the type of service; the start and end times of the service; the signature and title of each staff member who documents their time; and the nature of services. <p>6. 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.</p>	<p>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed, which contained the required information for 1 of 30 individuals.</p> <p>Individual #15 February 2019</p> <ul style="list-style-type: none"> The Agency billed a total of 1 unit of Case Management for February 2019. No documentation was found to justify 1 unit billed. Evidence indicated that only one visit had occurred. Per standards JCMs require two face-to-face contacts per month to bill the monthly unit. <p>March 2019</p> <ul style="list-style-type: none"> The Agency billed a total of 1 unit of Case Management for March 2019. No documentation was found to justify 1 unit billed. <p><i>Note: Findings for Individual #15 upheld by IRF 6/18/2019.</i></p>	<p>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?): →</p> <p>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?): →</p>	<p> </p>

Date: June 19, 2019

To: Andrea Gonzales, Executive Director / Case Manager
Provider: A New Vision Case Management Inc.
Address: 3949 Corrales Road, Suite 115
City, State, Zip: Corrales, New Mexico 87048

E-mail Address: bluebirdcm@outlook.com

Region: Metro
Survey Date: April 26 – May 2, 2019

Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: **2007, 2012 & 2018**: Case Management

Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Gonzales,

Your request for a Reconsideration of Findings was received on May 24, 2019. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 4C12

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the information provided, QMB acknowledges (per the document request form) that months in which a home visit were not completed include March 2019 for Individual #23. However, adding this month or adjusting the finding on the report of findings to reflect a missing home visit for the months of January - March 2019 does not change the outcome of the finding which currently lists no home visits for the months of November 2018 – February 2019. Documentation to rectify this finding should be provided during the Plan of Correction Process. In addition, the finding for Individual #23 will remain as documentation for visits completed in February and March 2019 was requested on the QMB Document Request Form and signed by Andrea Gonzales, on 4/30/2019. A final copy of the QMB Documentation Request form was provided to and signed by Sharon Kirkman on 5/02/2019, indicating acknowledgment of the findings. No documentation and/or justification was provided at the time of the on-site survey to dispute the finding.

Regarding Tag # 4C21

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the QMB Documentation Request Form, evidence to verify on-site monitoring of Individual #15

was completed in February and March 2019 was requested from and signed by Andrea Gonzales, on 4/30/2019. A final copy of the QMB Documentation Request form was provided to and signed by Sharon Kirkman on 5/02/2019 indicating acknowledgment of the findings. No documentation and/or justification was provided at the time of the on-site survey to dispute the finding.

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

Thank you.
Respectfully,

Crystal Lopez-Beck

Crystal Lopez-Beck
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

Q.19.4.DDW.D3715.5.RTN.12.19.170

Date: July 22, 2019

To: Andrea Gonzales, Executive Director / Case Manager
Provider: A New Vision Case Management Inc.
Address: 3949 Corrales Road, Suite 115
City, State, Zip: Corrales, New Mexico 87048

E-mail Address: bluebirdcm@outlook.com

Region: Metro
Survey Date: April 26 – May 2, 2019

Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: **2007, 2012 & 2018**: Case Management

Survey Type: Routine

Dear Mrs. Gonzales;

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,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI