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Date: March 31, 2016

To: Lecie McNees, Executive Director  
Provider: Visions Case Management and Consulting Services, Inc.  
Address: 1570 Pacheco Suite B-7  
State/Zip: Santa Fe, New Mexico 87505

E-mail Address: [lecie@visionsnm.com](mailto:lecie@visionsnm.com)

CC: Charles Clayton, Mi Via Consulting Program Manager  
E-mail Address: [charles@visionsnm.com](mailto:charles@visionsnm.com)

Region: Northeast  
Survey Date: February 26 - March 3, 2016  
Program Surveyed: Mi Via Waiver

Service Surveyed: Mi Via Consultation Services  
Survey Type: Initial

Team Leader: Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Valerie V. Valdez, MS, Bureau Chief, Division of Health Improvement/Quality Management Bureau and Crystal Lopez-Beck, BA, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau

Dear Ms. McNees and Mr. Clayton;

The Division of Health Improvement/Quality Management Bureau Mi Via Survey Unit 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.

**Plan of Correction:**

The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's 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.

During the exit interview of your on-site survey Attachment A on the Plan of Correction Process was provided to you. Please refer to 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:**

**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 – Visions Case Management and Consulting Services, Inc.– Northeast Region – February 26 – March 3, 2016

Survey Report #: Q.14.3.MVW.D1667.2.INT.01.16.091

- 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? (i.e. file reviews, periodic check with checklist, 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)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORI, etc.)

**Submission of your Plan of Correction:**

Please submit your agency’s Plan of Correction in the space on the right-hand column 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: Plan of Correction Coordinator**  
**1170 North Solano Suite D Las Cruces, NM 88001**
- 2. Developmental Disabilities Supports Division**  
**Attention: Mi Via Program Manager**  
**5301 Central Ave. NE Suite 200 Albuquerque, NM 87108**

Upon notification 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.

**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:

QMB Deputy Bureau Chief  
 5301 Central Ave NE Suite #400  
 Albuquerque, NM 87108  
 Attention: IRF request

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 QMB Plan of Correction Coordinator 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,

*Erica Nilsen, BA*

Erica Nilsen, BA  
 Team Lead/Healthcare Surveyor  
 Division of Health Improvement  
 Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: February 29, 2016

Present: **Visions Case Management and Consulting Services, Inc.**  
Lecie McNees, Executive Director  
Carolane McNees, QA/IMB Coordinator  
Barbara Pribble, Office Manager  
Charles Clayton, Consultant/Mi Via Consulting Program Manager

**DOH/DHI/QMB**

Erica Nilsen, BA, Team Lead/Healthcare Surveyor  
Valerie V. Valdez, MS, Bureau Chief  
Crystal Lopez-Beck, Deputy Bureau Chief

Exit Conference Date: March 3, 2016

Present: **Visions Case Management and Consulting Services, Inc.**  
Lecie McNees, Executive Director  
Carolane McNees, QA/IMB Coordinator  
Barbara Pribble, Office Manager  
Charles Clayton, Consultant/Mi Via Consulting Program Manager

**DOH/DHI/QMB**

Erica Nilsen, BA, Team Lead/Healthcare Surveyor  
Valerie V. Valdez, MS, Bureau Chief  
Crystal Lopez-Beck, Deputy Bureau Chief

**DDSD – Mi Via Program**

Christine Wester, Mi Via Program Manager

Administrative Locations Visited	Number:	1
Total Sample Size	Number:	31
Participant Records Reviewed	Number:	31
Consultant Staff Records Reviewed	Number:	3

### Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Participant Program Case Files
- Personnel Files
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Quality Assurance / Improvement Plan

CC: Distribution List:

DOH - Division of Health Improvement  
DOH - Developmental Disabilities Supports Division  
DOH - Office of Internal Audit  
HSD - Medical Assistance Division  
MFEAD – NM Attorney General

## 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 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](mailto:AmandaE.Castaneda@state.nm.us). Requests for technical assistance must be requested through your Regional DDSD Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

#### **Instructions for Completing Agency POC:**

##### **Required Content**

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, 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 Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:**

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 individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan

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

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

**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](mailto: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](mailto: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 the documents do not contain protected Health information (PHI) the preferred method is that you 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 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: <http://dhi.health.state.nm.us/qmb>
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](mailto: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.

**Agency:** Visions Case Management and Consulting Services, Inc.— Northeast Region  
**Program:** Mi Via Waiver  
**Service:** Consultant Services  
**Monitoring Type:** Initial Survey  
**Survey Date:** February 26 - March 3, 2016

Tag	Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI, Responsible Party and Date Due
4.5	<b>Pre-Eligibility and Enrollment Services</b>		
	<p> <b>Mi Via Self-Directed Waiver Program Service Standards effective February 2012</b>   <b>Section 4. Mi Via Contractors and Supports C. Consultant Agencies, Consultants and Support Guides</b>   <b>Pre-Eligibility and Enrollment Services</b>            Consultant Pre-Eligibility/Enrollment Services are intended to provide information, support, guidance, and/or assistance to individuals during the Medicaid eligibility process, which includes both financial and medical components. During this phase, consultants will           <ul style="list-style-type: none"> <li>• Meet with the participant for an initial orientation and enrollment meeting;</li> <li>• Inform, support, and assist as necessary with the requirements for establishing the LOC;</li> <li>• Assist with financial eligibility application and paperwork as needed; and</li> <li>• Verify that the county ISD office of the HSD has completed a determination that the individual meets financial and medical eligibility to participate in the Mi Via Waiver program.</li> </ul> <b>Appendix A:</b>   <b>Service Descriptions in Detail 2009 Waiver</b> </p>	<p>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 2 of 31 participants.</p> <p>Review of the Agency’s participant case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• Evidence the Consultant made contact with the participant within five business days of receipt of primary freedom of choice. (#15, 19)</li> </ul>	<p> <b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> <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> <b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →         </p>

<p><b>Renewal</b></p> <p><b>CONSULTANT/SUPPORT GUIDE</b></p> <p><b>PRE-ELIGIBILITY/ENROLLMENT SERVICES</b></p> <p><b>II. Scope of Service</b>  Consultant pre-eligibility/enrollment services are delivered in accordance with the individual's identified needs. Based upon those needs, the consultant provider selected by the individual shall:</p> <p>A. Assign a consultant and contact the individual within five (5) working days after receiving the PFOC to schedule an initial orientation and enrollment meeting;</p> <p>B. The actual enrollment meeting should be conducted within 30 days. Enrollment activities include but are not limited to:</p> <ol style="list-style-type: none"> <li>1. General program overview including key agencies and contact information;</li> <li>2. Discuss medical and financial eligibility requirements and offer assistance in completing these requirements as needed;</li> <li>3. Provide information on Mi Via participant roles and responsibilities;</li> <li>4. Discussion of Employer of Record (EOR) including discussion and possible identification of an EOR and completion of the EOR information form;</li> <li>5. Review the processes for hiring employees and contractors and required paperwork;</li> <li>6. Review the process and paperwork for hiring Legally Responsible Individuals (LRI) as employees;</li> </ol>		
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	<p>7. Discuss the background check and other credentialing requirements for employees and contractors;</p> <p>8. Referral for accessing training for the GCES <i>on-line</i> system; and to obtain information on the Financial Management Agency (FMA); and</p> <p>9. Provide information on the Service and Support Plan (SSP) including covered goods and services, planning tools and community resources available.</p> <p>Mi Via Consultant Guide (4/12) pg. 16  Mi Via Consultant Guide (4/12) pg. 31  Mi Via Consultant Guide (4/12) pg. 33</p>		
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4.6	On-going Consultant Functions		
	<p><b>Mi Via Self-Directed Waiver Program Service Standards effective February 2012</b></p> <p><b>Section 4. Mi Via Contractors and Supports C. Consultant Agencies, Consultants and Support Guides</b></p> <p><b>On-going Consultant Functions</b>            After eligibility has been verified, consultants assist the participant with virtually every aspect of the Mi Via program. The extent of assistance is based upon individual participant needs, and may include (but is not limited to) help and guidance related to</p> <ul style="list-style-type: none"> <li>• Understanding participant and EOR roles and responsibilities;</li> <li>• Identifying resources outside the Mi Via program, including natural and informal supports, that may assist in meeting the participant's needs;</li> <li>• Understanding the array of Mi Via covered supports, services, and goods;</li> <li>• Developing a thoughtful and comprehensive SSP/budget that includes services and supports, covered by the Mi Via program, to address the needs of the participant;</li> <li>• Developing, documenting and submitting an appropriate SSP/budget request to implement the SSP/budget;</li> <li>• Employer-related activities such as identifying an EOR, finding and hiring employees and contractors, and completing all documentation required by the FMA;</li> <li>• Identifying and resolving issues related to the implementation of the SSP/budget;</li> <li>• Assist the participant with quality assurance activities to ensure implementation of the participant's SSP/budget, and utilization of the authorized budget; and</li> <li>• Recognizing and reporting critical incidents, including abuse, neglect, exploitation, emergency services, law enforcement involvement, and environmental hazards.</li> </ul>	<p>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 23 of 31 participants.</p> <p>Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• Client Individual Assessment (CIA) (#4)</li> <li>• Vineland Assessment (#4)</li> <li>• Authorized Agent Acknowledgement Form (#9)</li> <li>• Guardianship Documents (#16)</li> <li>• Choosing Mi Via: Understanding Participant Responsibilities Acknowledgement Form (#5, 8, 16, 17)</li> <li>• Emergency Backup Plan Acknowledgement Form (#5, 29, 31)</li> <li>• Evidence that the participant received a copy of their approved SSP was not found. (#4, 5, 7, 8, 11, 13, 14, 15, 16, 17, 19, 20, 22, 24, 26, 27, 28, 30) <i>(Note: No POC Required for Individuals #4, 7, 8, 11, 13, 14, 15, 16, 17, 19, 20, 22, 24, 26, 27, 28, 30)</i></li> </ul> <p><b>Monthly Contacts</b></p> <ul style="list-style-type: none"> <li>• Individual #30 - None found for 8/2015.</li> <li>• Individual #32 - None found for 11/2015.</li> </ul> <p><b>Quarterly Visits</b></p> <ul style="list-style-type: none"> <li>• Individual #31 – None found for 11/2015-1/2016.</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> <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><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>

<p>Consultants will contact the participant at least once a month for a 'check-in' and meet face-to-face with the participant at least once every three (3) months to</p>	<ul style="list-style-type: none"> <li>• Review spending patterns;</li> <li>• Review and document progress of SSP/budget implementation;</li> <li>• Document the usage and effectiveness of the 24-hour Emergency Backup Plan;</li> <li>• Document the purchase of goods;</li> <li>• Review and document the progress of the SSP/budget implementation; and</li> <li>• Document the usage and effectiveness of the 24-hour emergency backup plan.</li> <li>• revisions.</li> </ul>	<p>NMAC 8.314.6.12, Record Keeping and Documentation Responsibilities</p>	<p>NMAC 8.302.1.17 NMAC - Record Keeping and Documentation Requirements</p>	<p>NMAC 8.302.1 NMAC - General Provider Policies</p>	<p>New Mexico Human Services Register Vol. 34, No 10 March 14, 2011 Pg. 8</p>	<p>Mi Via Consultant Guide (4/12) pg. 31</p>	<p>Mi Via Consultant Guide (4/12) pg. 63 – Incident Management Process for Aged &amp; Disabled and Brain Injury</p>	<p>NMAC 7.1.14, Abuse, Neglect, Exploitation, Suspicious Injury and Unexpected Death Reporting, Intake, Processing and Training Requirements for Community Based Service Providers</p>	<p>Mi Via Consultant Guide (4/12) – Appendix L, Pg. 107 – Documentation of Services Policy</p>		
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	State of NM, DOH, DDSD Terms of the Provider Agreement		
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1A25	Caregiver and Hospital Caregiver Employment Requirements		
	<p><b>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:</b>  <b>F. Timely Submission:</b> Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</p> <p><b>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:</b>  <b>A. Prohibition on Employment:</b> A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</p> <p>(1) In cases where the criminal history record lists an arrest for a crime that would constitute a disqualifying conviction and no final disposition is listed for the arrest, the department will attempt to notify the applicant, caregiver or hospital caregiver and request information from the applicant, caregiver or hospital caregiver within timelines set forth in the department's notice regarding the final disposition of the arrest. Information requested by the department may be evidence, for example, a certified copy of an acquittal, dismissal or conviction of a lesser included crime.</p> <p>(2) An applicant's, caregiver's or hospital caregiver's failure to respond within the required timelines regarding the final disposition of the arrest for a crime that would constitute a disqualifying conviction shall result in the applicant's, caregiver's or hospital caregiver's temporary disqualification from employment as a caregiver or hospital caregiver pending written documentation submitted to the</p>	<p>Based on record review, the Agency did not maintain documentation in the employee's personnel records indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 1 of 3 Agency Personnel.</p> <p><b>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</b></p> <ul style="list-style-type: none"> <li>• #302 – Date of hire 3/1/2015 (Fingerprints Submitted on 3/3/2016)</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</p> <p><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</p>

<p>department evidencing the final disposition of the arrest. Information submitted to the department may be evidence, for example, of the certified copy of an acquittal, dismissal or conviction of a lesser included crime. In instances where the applicant, caregiver or hospital caregiver has failed to respond within the required timelines the department shall provide notice by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A., of Section 7.1.9.9.</p> <p><b>(3)</b> The department will not make a final determination for an applicant, caregiver or hospital caregiver with a pending potentially disqualifying conviction for which no final disposition has been made. In instances of a pending potentially disqualifying conviction for which no final disposition has been made, the department shall notify the care provider, applicant, caregiver or hospital caregiver by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A, of Section 7.1.9.9.</p> <p><b>B. Employment Pending Reconsideration Determination:</b> At the discretion of the care provider, an applicant, caregiver or hospital caregiver whose nationwide criminal history record reflects a disqualifying conviction and who has requested administrative reconsideration may continue conditional supervised employment pending a determination on reconsideration.</p> <p><b>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.</b> The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:</p> <p><b>A.</b> homicide;</p> <p><b>B.</b> trafficking, or trafficking in controlled substances;</p> <p><b>C.</b> kidnapping, false imprisonment, aggravated assault or aggravated battery;</p>		
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	<p><b>D.</b> rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;</p> <p><b>E.</b> crimes involving adult abuse, neglect or financial exploitation;</p> <p><b>F.</b> crimes involving child abuse or neglect;</p> <p><b>G.</b> crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</p> <p><b>H.</b> an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p>		
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1A26	Employee Abuse Registry / Consolidated Online Registry		
	<p><b>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:</b> Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. <b>Provider requirement to inquire of registry.</b> A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. <b>Prohibited employment.</b> A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. <b>Documentation of inquiry to registry.</b> The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the</p>	<p>Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 1 of 3 Agency Personnel.</p> <p><b>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</b></p> <ul style="list-style-type: none"> <li>• #302 – Date of hire 3/1/2015. Completed on 2/29/2016.</li> </ul>	<p><b>Provider:</b>  <b>State your Plan of Correction for the deficiencies cited in this tag here</b> <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><b>Provider:</b>  <b>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here</b> <i>(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</i> →</p>

<p>provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. <b>Documentation for other staff.</b> With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.</p> <p>F. <b>Consequences of noncompliance.</b> The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.</p>		
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Date: June 16, 2016

To: Lecie McNeese, Executive Director  
Provider: Visions Case Management and Consulting Services, Inc.  
Address: 1570 Pacheco Suite B-7  
State/Zip: Santa Fe, New Mexico 87505

E-mail Address: [lecie@visionsnm.com](mailto:lecie@visionsnm.com)

CC: Charles Clayton, Mi Via Consulting Program Manager  
E-mail Address: [charles@visionsnm.com](mailto:charles@visionsnm.com)

Region: Northeast  
Survey Date: February 26 - March 3, 2016  
Program Surveyed: Mi Via Waiver

Service Surveyed: Mi Via Consultation Services  
Survey Type: Initial

Dear Ms. McNeese and Mr. Clayton;

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.**

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 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

Q.14.3.MVV.D1667.2.INT.09.16.168