NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

Date:	May 1, 2024
To:	Sarah Martinez, Executive Director
Provider: Address: State/Zip:	Peak Developmental Services, Inc. 8501 Candelaria Rd. NE, Building A1 Albuquerque, New Mexico 87112
E-mail Address:	smartinez@nmddwcm.com
Region: Survey Date:	Metro, Northeast, Northwest, Southeast, and Southwest March 25 – April 9, 2024
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Case Management
Survey Type:	Routine
Team Leader(s):	Kory Chandler, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Nicole Devoti, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Sally Karingada, BS, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau
Team Members:	Jamie Pond, BS, Staff Manager Division of Health Improvement/Quality Management Bureau; Jessica Maestas, Healthcare Surveyor Division of Health Improvement/Quality Management Bureau; Armida Medina, Healthcare Surveyor Division of Health Improvement/Quality Management Bureau; Karlene Anderson, LMSW, Healthcare Surveyor Division of Health Improvement/Quality Management Bureau; Kayla Benally, BSW, Healthcare Surveyor Division of Health Improvement/Quality Management Bureau; Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor Division of Health Improvement/Quality Management Bureau; Marilyn Moreno, AA, Healthcare Surveyor Division of Health Improvement/Quality Bureau; Marie Passaglia, BA, Healthcare Surveyor Advanced & Plan of Correction Coordinator; Sally Rel, MS, Healthcare Surveyor Division of Health Improvement/Quality Management Bureau

Dear Ms. Sarah Martinez,

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

Determination of Compliance:

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

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

The following tags are identified as Condition of Participation Level:

- Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File
- Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components
- Tag # 4C01.1 Case Management Services – Utilization of Services
- Tag # 4C02 Scope of Services - Primary Freedom of Choice
- Tag # 4C07 Individual Service Planning *(Visions, measurable outcome, action steps)*
- Tag # 4C07.2 Person Centered Assessment and Career Development Plan
- Tag # 4C08 ISP Development Process
- Tag # 4C09 Secondary Freedom of Choice (SFOC)
- Tag # 4C12 Monitoring & Evaluation of Services
- Tag # 4C15.1 Service Monitoring: Semi-Annual Reports
- Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)
- Tag # 4C04 Assessment Activities
- Tag # 1A22 / 4C02 Case Manager: Individual Specific Competencies
- Tag # 1A22.1 / 4C02.1 Case Manager Competencies: Job Knowledge
- Tag # 1A26 Employee Abuse Registry
- Tag # 1A27.0 Immediate Action and Safety Plan
- Tag # 1A28.4 Incident Mgt: Case Manager Knowledge of IMB Notification Responsibility
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)

Plan of Correction:

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

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

Corrective Action for Current Citation:

- How is the deficiency going to be corrected? (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, Monica Valdez, Plan of Correction Coordinator** at MonicaE.Valdez@doh.nm.gov

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
PO Box 2348
1474 Rodeo Road
Santa Fe, New Mexico 87505

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

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

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

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

ATTN: QMB Bureau Chief
Request for Informal Reconsideration of Findings
5300 Homestead Rd NE, Suite 300-331
Albuquerque, NM 87110
Attention: IRF request/QMB

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

composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@doh.nm.gov if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Kory Chandler, Kory Chandler
Co-Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Nicole Devoti, BA, Nicole Devoti
Co-Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Sally Karingada, BS, Sally Karingada
Co-Team Lead/Healthcare Surveyor Supervisor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	March 25, 2024
Contact:	**Peak Developmental Services, Inc.** Sarah Martinez, Executive Director **DOH/DHI/QMB** Kory Chandler, Co-Team Lead/Healthcare Surveyor Nicole Devoti, Co-Team Lead/Healthcare Surveyor Sally Karingada, Co-Team Lead/Healthcare Surveyor Supervisor
Entrance Conference Date:	*(Note: Entrance meeting waived by provider)*
Exit Conference Date:	April 9, 2024
Present:	**Peak Developmental Services, Inc.** Sarah Martinez, Executive Director Vanessa Inight, Case Manager Kent Williamson, Case Manager Claudia McPherson, Case Manager Gerith Chavez, Case Manager Kevin Jones, Case Manager **DOH/DHI/QMB** Sally Karingada, BS, Healthcare Surveyor Supervisor/Co-Lead Nicole Devoti, BA, Healthcare Surveyor/Co-Lead Koren Chandler, Healthcare Surveyor/Co-Lead Jamie Pond, BS, Staff Manager Jessica Maestas, Healthcare Surveyor Elizabeth Vigil, Healthcare Surveyor Armida Medina, Healthcare Surveyor Karlene Anderson, LMSW, Healthcare Surveyor Kayla Benally, BSW, Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor Marilyn Moreno, AA, Healthcare Surveyor Marie Passaglia, BA, Healthcare Surveyor Advanced / Plan of Correction Coordinator **DDSD – Northwest, Southeast, Southwest Regional Offices** Aaron Joplin, Northwest Regional Director Guy Irish, Southeast Regional Manager Jacqueline Marquez, Southwest Social & Community Service Coordinator Marie Velasco, Statewide DDW Program Manager
Administrative Locations Visited:	0 (*Administrative portion of survey completed remotely*)
Total Sample Size:	100
Persons Served Records Reviewed	100
Total Number of *Secondary Freedom of Choices* Reviewed:	Number: 405
Case Management Personnel Records Reviewed	55

Case Manager Personnel Interviewed	51
Administrative Interview	1

Administrative Processes and Records Reviewed:

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

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
HSD - Medical Assistance Division

Attachment A

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

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

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

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the DDSD Regional Office for purposes of contract management or the Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings. Providers who fail to complete a POC within the 45-business days allowed will be referred to the IRC for possible actions or sanctions.

Requests for technical assistance must be requested through your Regional DDSD Office.

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

Instructions for Completing Agency POC:

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

If a deficiency has already been corrected since the on-site survey, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

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

The Plan of Correction must address each deficiency cited in the Report of Findings unless otherwise noted with a "No Plan of Correction Required statement." The Plan of Correction must address the five (5) areas listed below:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented, and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@doh.nm.gov for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your respective Regional DDSD Office.
4. Submit your POC to via email to MonicaE.valdez@doh.nm.gov. Please also submit your POC to your Developmental Disabilities Supports Division Regional Office for region of service surveyed.
5. ***Do not submit supporting documentation*** (evidence of compliance) to QMB ***until after*** **your POC has been approved** by the QMB.
6. QMB will notify you when your POC has been "approved" or "denied."
    a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45-business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
    b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.
    c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

Once your POC has been approved by the QMB Plan of Correction Coordinator, you must submit copies of documents as evidence that all deficiencies have been corrected. You must also submit evidence of the ongoing Quality Assurance/Quality Improvement processes.

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

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

Attachment B

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

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

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

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

Conditions of Participation (CoPs)

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

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

<u>Service Domain: Plan of Care ISP Development & Monitoring -</u> *Service plans address all participates' assessed needs (including health and safety risk factors) and goals, either by waiver services or through other means. Services plans are updated or revised at least annually or when warranted by changes in the waiver participants' needs.*

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

- **1A08.3 –** Administrative Case File - Individual Service Plan (ISP) / ISP Components
- **4C07 –** Individual Service Planning (Visions, measurable outcome, action steps)
- **4C07.1 –** Individual Service Planning – Paid Services
- **4C10 –** Apprv. Budget Worksheet Waiver Review Form / MAD 046
- **4C12 –** Monitoring & Evaluation of Services
- **4C16 –** Requirements for Reports & Distribution of ISP (Provider Agencies, Individual and/or Guardian)

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

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

- **4C04 –** Assessment Activities

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

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

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

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

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

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

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

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

Attachment C

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

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

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Bureau Chief **within 10 business days** of receipt of the final Report of Findings **(*Note: No extensions are granted for the IRF)*.**
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: Microsoft Word - IRF-QMB-Form.doc (nmhealth.org)
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Valerie V. Valdez at valerie.valdez@doh.nm.gov for assistance.

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

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

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

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

Attachment D

QMB Determinations of Compliance

Compliance:

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

Partial-Compliance with Standard Level Tags:

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

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

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

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

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

Non-Compliance:

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

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

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

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

Agency: **Peak Developmental Services, Inc. - Metro, Northwest, Northeast, Southeast and Southwest Regions**
Program: Developmental Disabilities Waiver
Service: Case Management
Survey Type: Routine
Survey Date: **March 25 - April 9, 2024**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Plan of Care - ISP Development & Monitoring – *Service plans address all participates' assessed needs (including health and safety risk factors) and goals, either by waiver services or through other means. Services plans are updated or revised at least annually or when warranted by changes in the waiver participants' needs.*			
Tag # 1A08 Administrative Case File	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements**: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and	Based on record review, the Agency did not maintain a complete client record at the administrative office for 2 of 100 individuals. Review of the Agency individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Behavior Crisis Intervention Plan:** • Not Found (#99) **Speech Therapy Initial / Re-Evaluation Report:** • Initial Evaluation Not Found (#65) **Physical Therapy Initial / Re-Evaluation Report:** • Annual Re-evaluation Not Found (#65)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

essential to ensuring the health and safety of the person during the provision of the service. 2. Records must contain information of concerns related to abuse, neglect or exploitation. 3. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices are acceptable. 4. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all settings. 5. 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. 6. 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. 7. 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. 8. All records must be retained for six (6) years and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.			

Tag # 1A08.3 Administrative Case File – Individual Service Plan / ISP Components	Standard Level Deficiency		
NMAC 7.26.5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY. **NMAC 7.26.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS.** **NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS.** Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 6: Individual Service Plan (ISP): 6.2 IDT Membership and Meeting Participation:** The Interdisciplinary Team (IDT) membership and meeting participation varies per person. 1. At least the following IDT participants are required to contribute: a. the person receiving services and supports; b. court appointed guardian or parents of a minor, if applicable; c. CM; d. friends requested by the person; e. family member(s) and/or significant others requested by the person; f. DSP who provide the on-going, regular support to the person in the home, work, and/or recreational activities; g. Provider Agency service coordinators; and h. ancillary providers such as the OT, PT, SLP, BSC, nurse and nutritionist, as appropriate; and i. healthcare coordinator… **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	Based on record review, the Agency did not maintain a complete client record at the administrative office for 12 of 100 individuals. Review of the Agency individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Addendum A w/ *Incident Mgt. System - Parent/Guardian Training*:** • Not Found (#65) **DDSD Assessment Tracking Sheet – Assessment Checklist:** • Not Found (#52) **ISP Signature Page:** • Not Fully Constituted IDT *(No evidence of Nurse involvement)* (#30) • Not Fully Constituted IDT *(No evidence of Individual, Guardian, Occupational Therapist and Behavior Support Consultant involvement)* (#43) • Not Fully Constituted IDT *(No evidence of Occupational Therapist involvement)* (#62) • Not Fully Constituted IDT *(No evidence of Nurse and Physical Therapist involvement)* (#65) • Not Fully Constituted IDT *(No evidence of Physical Therapist involvement)* (#74) • Not Fully Constituted IDT *(No evidence of Nurse involvement)* (#84)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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 and status of the individual. **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements**: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced….	• Not Fully Constituted IDT *(No evidence of Nurse involvement)* (#91) • Not Fully Constituted IDT *(No evidence of Occupational Therapist involvement)* (#92) **ISP Teaching & Support Strategies:** ***Individual #59:*** *TSS not found for the following Work Outcome Statement / Action Steps:* • "…will research and find sensory activities of her choice to participate in." ***Individual #65:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "...will participate in his tabletop activities." *TSS not found for the following Fun Outcome Statement / Action Steps:* • "...will research community activities." • "...will participate in community activities" • "...will try a new community activity. " ***Individual #94:*** *TSS not found for the following Fun Outcome Statement / Action Steps:* • "…will participate in community activities." ***Individual #95:*** *TSS not found for the following Work Outcome Statement / Action Steps:* • "…will work at Subway."		

Tag # 4C01.1 Case Management Services – Utilization of Services	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8 Case Management: 8.2.7 Monitoring and Evaluating Service Delivery:** The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health, safety and abuse free environment of the person. Monitoring and evaluation activities include the following requirements:… 14. The CM must monitor utilization of budgets by reviewing in the Medicaid Web Portal monthly in preparation for site visits. The CM uses the information to have informed discussions with the person/guardian about high or low utilization and to follow up with any action that may be needed to assure services are provided as outlined in the ISP with respect to: quantity, frequency and duration. Follow up action may include, but not be limited to: a. documenting extraordinary circumstances; b. convening the IDT to submit a revision to the ISP and budget as necessary; c. working with the provider to align service provision with ISP and using the RORA process if there is no resolution from the provider; and d. reviewing the SFOC process with the person and guardian, if applicable.	Based on interview, the Case Manager did not or was not aware of how to monitor the utilization of budgets by reviewing in the Medicaid Web Portal for 6 of 100 individuals. **When the Case Managers were asked, how do you monitor an Individual's Utilization of Services *(Is the Individual using the services identified in the budget)*, the following was reported:** • #510 stated, "I have the budget. With the therapists I ask them for their annual report and semiannual reports, and also contact with therapists by emailing, like OT for example, is the OT going to the house to work with her, the PT is the person going to the PT facility, talk to the house manager and see if going once a week. A lot of contact with team member…I am in contact with Therapists very regular, they contact me and I contact them. They ask if meeting is needed for services not being provided." Per DDW standards case managers must monitor utilization of budgets by reviewing in the Medicaid Web Portal monthly in preparation for site visits. • #547 stated, "With home visits and site visits, talking with staff and therapists, review semiannual reports. Talk with consumer if they are verbal. Follow up and see if this is a service they want to continue. Maybe take it off the budget or modify reduce it…If they are refusing or no therapist coming." Per DDW standards case managers must monitor utilization of budgets by reviewing in the Medicaid Web Portal monthly in preparation for site visits.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 4C02 Scope of Services - Primary Freedom of Choice	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **Chapter 1: Initial Allocation and Ongoing Eligibility: 1.4 Primary Freedom of Choice (PFOC):** The applicant completes the PFOC form to select between: 1. An Intermediate Care Facility for Individuals with Intellectual/Developmental Disability (ICF/IID); or 2. The DD Waiver and a Case Management Agency or the Mi Via Self-Directed Waiver and a Consultant Agency. 3. To place their allocation on hold or refuse the allocation: a. The applicant retains their original application date. It is the responsibility of the applicant to contact DDSD at a later date to take the allocation off hold at which time the applicant would be actively awaiting allocation based on their original registration date and available funding; or b. The applicant chooses not to receive services through ICF/IID nor DD Waiver or Mi Via now or in the future. The allocation will be closed, with a notice of rights to an Administrative Fair Hearing, and the applicant would need to re-apply for HCBS with a new application date should they choose to seek services in the future. **Chapter 4 Person Centered Planning (PCP): 4.4 Freedom of Choice of DD Waiver**	Based on record review, the Agency did not maintain documentation assuring individuals obtained all services through the freedom of choice process for 1 of 100 individuals. Review of the Agency individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Primary Freedom of Choice:** • Not Found (#65)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Provider Agencies: People receiving DD Waiver funded services have the right to choose any qualified provider of case management services listed on the PFOC (Primary Freedom of Choice) or CM Agency Change Form and a qualified provider of any other DD Waiver service listed on SFOC (Secondary Freedom of Choice) form. The CM Agency Change Forms are maintained by each Regional Office… **Chapter 9 Transitions:** … In any of these circumstances, appropriate planning must occur, and information must be provided to facilitate a smooth transition and informed choices. The CM plays a critical role in all types of transitions…**9.1 Change in Case Management Agency**: If a person or guardian selects a different case management agency, the following steps must be taken to ensure that critical issues affecting the person's health and safety do not get lost and a complete exchange of information and documentation occurs. 1. The person or guardian has the responsibility to contact their local DDSD Regional Office to complete the CM Agency Change form selecting the new Case Management Agency. 2. When the new Case Management Agency and DDSD receive the CM Agency Change form, file transfers must be completed within 30 calendar days. 3. The transferring Case Management Agency contacts the receiving Case Management Agency to schedule a transition meeting. 4. The transferring Case Management Agency must also inform the DDSD Regional Office(s) of the date and time of the transition meeting. This ensures that the Regional Office(s) are aware of the change and can be available to provide technical assistance as needed.			

Tag # 4C07 Individual Service Planning *(Visions, measurable outcome, action steps)*	Standard Level Deficiency		
NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS: Each ISP shall contain. B. Long term vision: The vision statement shall be recorded in the individual's actual words, whenever possible. For example, in a long term vision statement, the individual may describe him or herself living and working independently in the community. C. Outcomes: (1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP. (2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) … Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver… E. Action plans: (1) Specific ISP action plans that will assist the individual in achieving each identified, desired outcome shall be developed by the IDT and stated in the ISP. The IDT establishes the action plan of the ISP, as well as the criteria for measuring progress on each action step.	Based on record review, the Agency did not ensure the ISP was developed in accordance with the rule governing ISP development, for 5 of 100 Individuals. The following was found with regards to ISP: **Individual #43:** • Work/Learn Outcome: "…will volunteer in the community." Outcome was not measurable, as it did not indicate how and/or when it would be completed. **Individual #53:** • Fun Outcome: "...would like to develop and maintain a healthy relationship with her peers." Outcome was not measurable, as it did not indicate how and/or when it would be completed. **Individual #75:** • Live Outcome: "... wants to be able to communicate her needs and wants in ways that people can understand her." Outcome was not measurable, as it did not indicate how and/or when it would be completed. • Fun Outcome: "... would like maintain a close relationship with her family…will work on building relationships." Outcome was not measurable, as it did not indicate how and/or when it would be completed. **Individual #88** • Vision for Fun, " "I want to plan and take a vacation." Outcome indicates, "… will improve or maintain his general health and	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

(2) Service providers shall develop specific action plans and strategies (methods and procedures) for implementing each ISP desired outcome. Timelines for meeting each action step are established by the IDT. Responsible parties to oversee appropriate implementation of each action step are determined by the IDT. (3) The action plans, strategies, timelines and criteria for measuring progress, shall be relevant to each desired outcome established by the IDT. The individual's definition of success shall be the primary criterion used in developing objective, quantifiable indicators for measuring progress. Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 6: Individual Service Plan (ISP):** **6.6.1 Vision Statement:** The long-term vision statement describes the person's major long-term (e.g., within one to three years) life dreams and aspirations in the following areas: 1. Live, 2. Work/Education/Volunteer, 3. Develop Relationships/Have Fun, and 4. Health and/or Other (Optional). **6.6.2 Desired Outcomes:** A Desired Outcome is required for each life area (Live, Work, Fun) for which the person receives paid supports through the DD Waiver. Each service does not need its own, separate outcome, but should be connected to at least one Desired Outcome. Desired outcomes must: 1. be directly linked to a Vision; 2. be meaningful; 3. be measurable; 4. allow for skill building or personal growth; 5. be desired by the person, 6. not contain "readiness traps" or artificial barriers and steps others would not need to complete to pursue desired goals; and	wellbeing." Review of ISP found outcome is not tied to the person's vision statement. **Individual #95:** • Fun Outcome: "... will do new activities and trips with friends." Outcome was not measurable, as it did not indicate how and/or when it would be completed.		

7. not be achievable with little to no effort (e.g., open a savings account or one-time action).			

Tag # 4C07.2 Person Centered Assessment and Career Development Plan	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements**: All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced…. **Chapter 11 Community Inclusion: 11.4 Person Centered Assessments (PCA) and Career Development Plans (CDP)**	Based on record review, the Agency did not maintain a complete case file at the administrative office for 1 of 100 individuals. Review of the Agency individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Person Centered Assessment:** • Not Found (#24)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 4C08 ISP Development Process	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 2: Human Rights: 2.2.1 Statement of Rights Acknowledgement Requirements**: The CM is required to review the Statement of Rights (See DDW Standards Appendix C HCBS Rights and Freedoms) with the person, in a manner that accommodates preferred communication style, at the annual meeting. The person and their guardian, if applicable, sign the acknowledgement form at the annual meeting. **Chapter 8: Case Management: 8.2.1 Promoting Self Advocacy and Advocating on Behalf of the Person in Services:** A primary role of the CM is to facilitate self-advocacy and advocate on behalf of the person, which includes, but is not limited to: **8.2.8 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.	Based on record review, the Agency did not maintain documentation for each person supported according to the following requirements for 3 of 100 individuals. Review of the records indicated the following: **Statement of Rights Acknowledgment:** • Not Found (#10, 43, 71)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 4C09 Secondary Freedom of Choice (SFOC)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **Chapter 4 Person Centered Planning (PCP): 4.4 Freedom of Choice of DD Waiver Provider Agencies:** People receiving DD Waiver funded services have the right to choose any qualified provider of case management services listed on the PFOC (Primary Freedom of Choice) or CM Agency Change Form and a qualified provider of any other DD Waiver service listed on SFOC (Secondary Freedom of Choice) form. The CM Agency Change Forms are maintained by each Regional Office. **4.4.2 Annual Review of SFOC:** Choice of Provider Agencies must be continually assured. A person has a right to change Provider Agencies if they are not satisfied with services at any time. 1. The SFOC form must be utilized when the person and/or legal guardian wants to change Provider Agencies. 2. The SFOC must be signed at the time of the initial service selection and reviewed annually by the CM and the person and/or guardian… **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	Based on record review, the Agency did not maintain the Secondary Freedom of Choice documentation (for current services) and/or ensure individuals obtained all services through the Freedom of Choice Process for 11 of 100 individuals. Review of the Agency individual case files revealed 19 out of 405 Secondary Freedom of Choices were not found and/or not agency specific to the individual's current services: **Secondary Freedom of Choice:** • Adult Nursing Services (#59) • Behavior Consultation (#65) • Community Integrated Employment Services (#95) • Customized Community Supports (#14, 58, 75, 78, 84) • Customized Community Supports – Group (#65) • Customized Community Supports – Individual (#65) • Family Living (#14, 46) • Occupational Therapy (#65) • Physical Therapy (#45, 65) • Speech Therapy (#20, 65, 84) • Supported Living (#65)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

records vary depending on the unique needs of the person receiving services and the resultant information produced….			

Tag # 4C12 Monitoring & Evaluation of Services	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **8.2.7 Monitoring and Evaluating Service Delivery**: The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health, safety and abuse free environment 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. Immediately report any concern of abuse, neglect and exploitation using the established reporting process outlined in Chapter 18.2 ANE Reporting and Evidence Preservation. 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 living in the community. 5. Face-to-face visits must occur as follows: a. At least one face-to-face visit per quarter shall occur at the person's home.	Based on record review, the Agency did not use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual for 4 of 100 individuals. **Review of the Therap ® Monthly Site Visit Form revealed face-to-face visits were not being completed as required by standard for the following individuals:** **Individual #53** No site visit was noted between 3/2023 – 6/2023. • 3/6/2023 - 1:30 - 2:30 PM - home • 4/15/2023 – 5:45 - 6:45 PM - home • 5/8/2023 – 1:30 - 2:30 PM - home • 6/10/2023 – 9:15 - 10:15 AM - home **Individual #65** No site visit was noted between 3/2023 - 2/2024. • 3/10/2023 – 12:30 - 1:30 PM – home • 4/24/2023 – 3:30 - 4:00 PM – home • 5/3/2023 – 3:30 - 4:00 PM – home • 6/19/2023 – 4:30 - 5:00PM – home • 7/31/2023 – 11:00 - 11:30 AM – home • 8/9/2023 - IDT meeting 1:00-1:30 PM – home	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

b. At least one face-to-face visit per quarter shall occur at the day program for people who receive CCS and or CIE in an agency operated facility. c. It is appropriate to conduct face-to-face visits with the person either during times when the person is receiving a service or during times when the person is not receiving a service. d. The CM considers the preferences of the person when scheduling face-to face-visits in advance. e. Face-to-face visits may be unannounced depending on the purpose of the monitoring. **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….	• 9/21/2023 – 1:30-2:30 PM – home • 10/26/2023 – 5:30-6:00 PM – home • 11/29/2023 – 3:30-4:00 PM – home • 12/18/2023 – 4:30-5:00 PM – home • 1/10/2024 – 3:30-4:00 PM – home • 2/16/2024 - IDT meeting 1:00-2:00 PM - home **Individual #75** No site visit was noted between 3/2023 – 6/2023. • 3/6/2023 – 12:00 - 1:00 PM – home • 4/21/2023 - 12:30 - 1:30 PM - home • 5/30/2023 - 10:45 - 11:45AM – home • 6/10/2023 - 11:45 - 12:45PM - home **Individual #83** No site visit was noted between 10/2023 - 2/2024. • 10/20/2023 – 9:00 - 11:00 PM – home • 11/17/2023 – 10:00 - 11:00 AM – home • 12/20/2023 - 2:30 - 3:30 PM – home • 1/19/2024 - 3:30 - 4:30 PM – home • 2/23/2024 - 3:30pm - 4:30 PM - home		

Tag # 4C15.1 Service Monitoring: Semi-Annual Reports	Standard Level Deficiency		
NMAC 7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **8.2.7 Monitoring and Evaluating Service Delivery:** The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health, safety and abuse free environment of the person.	Based on record review, the Agency did not ensure that reports and the ISP met required timelines and included the required contents for 8 of 100 individuals. Review of the Agency individual case files revealed no evidence of semi-annual reports for the following: **Supported Living Semi-Annual Reports:** • Individual #43 – None found for April 2023 – October 2023 *(Term of ISP 4/2023 – 3/2024)* **Family Living Semi-Annual Reports:** • Individual #68 – None found for June 2023 – August 2023. *(Term of ISP 11/2022 – 10/2023). (ISP Meeting held on: 8/7/2023)* **Customized In-Home Supports Semi-Annual Reports:** • Individual #77 – None found for September 2023 – December 2023. *(Term of ISP 3/2023 – 2/2024). (ISP Meeting held on: 12/9/2023)* • Individual #95 – None found for April 2023 – September 2023. *(Term of ISP 10/2022– 10/2023). (ISP Meeting held on: 10/10/2023)* **Customized Community Supports Semi-Annual Reports:** • Individual #40 – None found for April 2023 – July 2023. *(Term of ISP 10/2022 – 10/2023). (ISP Meeting held on: 8/2/2023)* • Individual #43 – None found for April 2023 – October 2023 *(Term of ISP 4/2023 – 3/2024).*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Monitoring and evaluation activities include the following requirements: **Chapter 19: Provider Reporting Requirements: 19.5 Semi-Annual Reporting:** The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports are required as follows: … 3. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days). 4. The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting.	• Individual #48 – None found for December 2022 – June 2023. *(Term of ISP 12/2022 – 12/2023).* • Individual #53 – None found for April 2023 – July 2023. *(Term of ISP 10/2022 – 9/2023). (ISP Meeting held on: 7/12/2023)* • Individual #65 – None found for May 2023 – October 2023. *(Term of ISP 5/2023 – 4/2024).* • Individual #68 – None found for June 2023 – August 2023. *(Term of ISP 11/2022 – 10/31/2023). (ISP Meeting held on: 8/7/2023)* • Individual #95 – None found for April 2023 – September 2023. *(Term of ISP 10/2022 – 10/2023). (ISP Meeting held on: 10/10/2023)* **Community Integrated Employment Services Semi-Annual Reports:** • Individual #95 – None found for April 2023 – September 2023. *(Term of ISP 10/2022 – 10/2023). (ISP Meeting held on: 10/10/2023)* **Nursing Semi - Annual Reports:** • Individual #53 – None found for April 2023 – July 2023. *(Term of ISP 10/2022 – 9/2023). (ISP Meeting held on: 7/12/2023)*		

Tag # 4C16 Req. for Reports & Distribution of ISP (Provider Agencies, Individual and / or Guardian)	Condition of Participation Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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: 1. CMs will provide complete copies of the ISP to the Provider Agencies listed in the budget, the person and the guardian, if applicable, at least 14 calendar days prior to the start of the new ISP. Copies shall include any related ISP minutes, TSS, IST Attachment A, Addendum A, signature page and revisions, if applicable. 2. CMs will provide complete copies of the ISP to the respective DDSD Regional Offices 14 calendar days prior to the start of the new ISP. **NMAC 7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:** A. The case manager shall provide copies of the completed ISP, with all relevant service provider strategies attached, within fourteen (14) days of ISP approval to: (1) the individual; (2) the guardian (if applicable); (3) all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons; (4) all other IDT members in attendance at the meeting to develop the ISP; (5) the individual's attorney, if applicable; (6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies;	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 24 of 100 Individual: The following was found indicating the agency failed to provide a copy of the ISP to the Provider Agencies, Individual and / or Guardian at least 14 calendar days prior to the start date of the new ISP: **No Evidence found indicating ISP was distributed:** • Individual #1: ISP was not provided to the Individual/Guardian, LCA Agency and CI Agency. • Individual #26: ISP was not provided to the Individual. • Individual #29: ISP was not provided to the Individual. • Individual #43: ISP was not provided to the Individual/Guardian, LCA Agency and CI Agency. • Individual #48: ISP was not provided to the Individual/Guardian. • Individual #50: ISP was not provided to the Individual.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

(7) for all developmental disabilities Medicaid waiver recipients, including *Jackson* class members, a copy of the completed ISP containing all the information specified in 7.26.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD; (8) for *Jackson* class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the *Jackson* lawsuit office of the DDSD. B. Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.	• Individual #55: ISP was not provided to the Individual. • Individual #59: ISP was not provided to the LCA Agency. • Individual #60: ISP was not provided to the Individual. • Individual #65: ISP was not provided to the Individual/Guardian, LCA Agency and CI Agency. • Individual #84: ISP was not provided to the Individual/Guardian. • Individual #94: ISP was not provided to the LCA Agency, Guardian. • Individual #95: ISP was not provided to the Individual, LCA Agency and CI Agency. • Individual #96: ISP was not provided to the Individual, LCA Agency, and CI Agencies **Evidence indicated ISP was provided after ISP start date:** • Individual #25*: ISP start date was 1/1/2024, ISP was sent to* Individual and / or Guardian Provider, and Agencies (LCA/CI), *on 2/12/2024.* • Individual #52*: ISP start date was 11/10/2023, ISP was sent to* Individual and / or Guardian *on 11/27/2023.* • Individual #56*: ISP start date was 12/13/2023, ISP was sent to SLP, Provider Agencies (LCA/CI) on 1/5/2024.*		

	• Individual #62*: ISP start date was 7/1/2023, ISP was sent to Provider Agencies (LCA/CI) on 8/15/2023.* • Individual #67*: ISP start date was 11/1/2023, ISP was delivered to Individual and/or Guardian on 1/4/2024.* • Individual #71*: ISP start date was 4/1/2024, ISP was sent to* Individual and / or Guardian, and Provider Agencies (LCA/CI), *on 4/5/2024.* • Individual #73*: ISP start date was 10/15/2023, ISP was sent to* LCA/CI Provider *on 4/5/2024.* • Individual #77*: ISP start date was 3/1/2024, ISP was sent to* Individual and / or Guardian, and Provider Agencies (LCA/CI), *on 3/6/2024.* • Individual #80*: ISP start date was 6/1/2023, ISP was sent to Guardian on 6/9/2023.* • Individual #98*: ISP start date was 9/13/2023, ISP was sent to LCA Agency on 9/25/2023.*		

Tag # 4C16.1 Req. for Reports & Distribution of ISP (Regional DDSD Office)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **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: 1. CMs will provide complete copies of the ISP to the Provider Agencies listed in the budget, the person and the guardian, if applicable, at least 14 calendar days prior to the start of the new ISP. Copies shall include any related ISP minutes, TSS, IST Attachment A, Addendum A, signature page and revisions, if applicable. 2. CMs will provide complete copies of the ISP to the respective DDSD Regional Offices 14 calendar days prior to the start of the new ISP. **NMAC 7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:** A. The case manager shall provide copies of the completed ISP, with all relevant service provider strategies attached, within fourteen (14) days of ISP approval to: (1) the individual; (2) the guardian (if applicable); (3) all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons; (4) all other IDT members in attendance at the meeting to develop the ISP; (5) the individual's attorney, if applicable; (6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies; (7) for all developmental disabilities Medicaid waiver recipients, including	Based on record review, the Agency did not follow and implement the Case Manager Requirement for Reports and Distribution of Documents as follows for 38 of 100 Individual: The following was found indicating the agency failed to provide a copy of the ISP to the respective DDSD Regional Office at least 14 calendar days prior to the start of the new ISP: **No Evidence found indicating ISP was distributed to the regional office:** • Individual #1 • Individual #26 • Individual #35 • Individual #48 • Individual #59 • Individual #62 • Individual #65 • Individual #73 • Individual #75 • Individual #82 • Individual #94 • Individual #95 • Individual #96 • Individual #97	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Jackson class members, a copy of the completed ISP containing all the information specified in 7.26.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD; (8) for *Jackson* class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the *Jackson* lawsuit office of the DDSD. B. Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.	**Evidence indicated ISP was provided after ISP start date:** • Individual #2*: ISP start date was 8/1/2023, ISP was sent to* DDSD Regional Office *on 9/26/2023.* • Individual #4*: ISP start date was 10/1/2023, ISP was sent to* DDSD Regional Office *on 11/8/2023.* • Individual #5*: ISP start date was 2/1/2024, ISP was sent to* DDSD Regional Office *on 2/29/2024.* • Individual #6*: ISP start date was 11/25/2023, ISP was sent to* DDSD Regional Office *on 2/24/2023.* • Individual #10*: ISP start date was 11/1/2023, ISP was sent to* DDSD Regional Office *on 2/1/2024.* • Individual #20*: ISP start date was 12/1/2023, ISP was sent to* DDSD Regional Office *on 4/6/2024.* • Individual #25*: ISP start date was 1/1/2024, ISP was sent to* DDSD Regional Office *on 2/12/2024.* • Individual #29*: ISP start date was 5/18/2023, ISP was sent to* DDSD Regional Office *on 7/14/2023.* • Individual #30*: ISP start date was 12/1/2023, ISP was sent to* DDSD Regional Office *on 12/15/2023.*		

	• Individual #36*: ISP start date was 10/1/2023, ISP was sent to* DDSD Regional Office *on 3/26/2024.* • Individual #45*: ISP start date was 9/1/2023, ISP was sent to* DDSD Regional Office *on 12/15/2023.* • Individual #50*: ISP start date was 12/21/2023, ISP was sent to* DDSD Regional Office *on 2/2/2024.* • Individual #52*: ISP start date was 11/10/2023, ISP was sent to* DDSD Regional Office *on 12/20/2023.* • Individual #53*: ISP start date was 10/1/2023, ISP was sent to* DDSD Regional Office *on 3/8/2024.* • Individual #56*: ISP start date was 12/13/2023, ISP was sent to* DDSD Regional Office *on 1/5/2024.* • Individual #60*: ISP start date was 8/1/2023, ISP was sent to* DDSD Regional Office *on 8/10/2023.* • Individual #67*: ISP start date was 11/1/2023, ISP was sent to DDSD Regional Office on 12/20/2023.* • Individual #69*: ISP start date was 9/1/2023, ISP was sent to DDSD Regional Office on 4/5/2024.* • Individual #71*: ISP start date was 4/1/2024, ISP was sent to DDSD Regional Office on 4/5/2024.*		

	• Individual #77*: ISP start date was 3/1/2024, ISP was sent to DDSD Regional Office on 3/8/2024.* • Individual #80*: ISP start date was 6/1/2023, ISP was sent to DDSD Regional Office on 3/25/2024.* • Individual #84*: ISP start date was 12/1/2023, ISP was sent to DDSD Regional Office on 3/28/2024.* • Individual #86*: ISP start date was 2/1/2024, ISP was sent to DDSD Regional Office on 2/23/2024.* • Individual #98*: ISP start date was 9/13/2023, ISP was sent to DDSD Regional Office on 9/25/2023.* • Individual #101*: ISP start date was 1/12/2024, ISP was sent to* DDSD Regional Office *on 2/26/2024.*		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Level of Care – *Initial and annual Level of Care (LOC) evaluations are completed within timeframes specified by the State.*			
Tag # 4C04 Assessment Activities	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **8.2.3 Facilitating Level of Care (LOC) Determinations and Other Assessment Activities:** The CM ensures that an initial evaluation for the LOC is complete, and that all participants are reevaluated for a LOC at least annually….The assessment tasks of the CM include, but are not limited to: 1. Completing, compiling, and/or obtaining the elements of the Long-Term Care Assessment Abstract packet to include: a. a Long-Term Care Assessment Abstract form (MAD 378); b. Client Individual Assessment (CIA); c. a current History and Physical; d. a copy of the Allocation Letter (initial submission only); and e. for children, a norm-referenced assessment. 2. Timely submission of a completed LOC packet for review **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…	Based on record review, the Agency did not complete, compile or obtain the elements of the Long-Term Care Assessment Abstract packet and / or submitted the Level of Care in a timely manner, as required by standard for 3 of 100 individuals. Review of the Agency individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Level of Care:** • Not Current (#26, 43) **Annual Physical:** • Not Found (#14)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A22 / 4C02 Case Manager: Individual Specific Competencies	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2 Scope** DD Waiver CMs must have knowledge of the requirements for the entire system to effectively provide and monitor services… **8.2.1 Promoting Self Advocacy and Advocating on Behalf of the Person in Services:** A primary role of the CM is to facilitate self-advocacy and advocate on behalf of the person… **8.3.1 CM Qualifications and Training Requirements:** 1. Within specified timelines, Case Management Provider Agencies must assure that all CMs meet the requirements for pre-service and core competency and ongoing annual training as specified in Chapter 17: Training Requirements… **Chapter 17: Training Requirements: 17.2 Training Requirements for CMs and Case Management Supervisors**: Individual Specific Training: Complete IST requirements in accordance with the specifications described in the ISP of each person supported**…**	Based on interview, the Agency did not ensure each case manager had the knowledge of the requirements for the entire system to effectively provide and monitor services or met the IST requirements in accordance with the specifications described in the ISP of each person supported for 4 of 51 Case Managers. **When the Case Managers were asked, if the Individual required any type of Assistive Technology or Adaptive Equipment, the following was reported:** • #524 stated, “None.” According to the ISP, the individual uses an iPad. (Individual #85) • #524 stated, “Glasses…Nope.” According to the ISP, the individual uses hearing aids. (Individual #81) **When the Case Managers were asked, if the Individual had Healthcare Plans and what they were the following was reported:** • #510 stated, “Constipation.” According to the Electronic Comprehensive Health Assessment Tool**,** the individual requires HCPs for BMI and Seizures. (Individual #39) • #516 stated, "No he does not, just a MERP for falls…I'm pretty sure but now you got me wondering so let me check. Nope, just the MERP." According to the Electronic Comprehensive Health Assessment Tool**,**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

	the individual requires an HCP for BMI. (Individual #36) • #534 stated, “He does for seizure disorder, constipation and BMI, he has lost some weight recently, aspiration.” According to the Electronic Comprehensive Health Assessment Tool, the individual requires an HCP for Endocrine. (Individual #18)		

Tag # 1A22.1 / 4C02.1 Case Manager Competencies: Job Knowledge	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2 Scope** DD Waiver CMs must have knowledge of the requirements for the entire system to effectively provide and monitor services… **8.2.1 Promoting Self Advocacy and Advocating on Behalf of the Person in Services:** A primary role of the CM is to facilitate self-advocacy and advocate on behalf of the person… **8.3.1 CM Qualifications and Training Requirements:** 1. Within specified timelines, Case Management Provider Agencies must assure that all CMs meet the requirements for pre-service and core competency and ongoing annual training as specified in Chapter 17: Training Requirements… 2. Case Management Provider Agencies must have professional development requirements in place to assure that all CMs engage in continuing education, DDSD trainings, professional skill building activities, and remediate any performance issues. 3. Case Management Provider Agencies and their staff/sub-contractors must adhere to all requirements communicated to them by DDSD, including participation in the Therap system, attendance at mandatory meetings and trainings, and participation in technical assistance sessions. 4. Case Management Provider Agencies and their staff/subcontractors must adhere to all training requirements to use secure and web-based systems to transfer information as required by the TPA. (This includes the TPA Web Portal and Secure CISCO system). 7. CMs, whether subcontracting or employed by a Provider Agency, shall have a working knowledge of the health and social resources available within a region…	Based on interview, the Agency did not ensure each case manager had the knowledge of the requirements for the entire system to effectively provide and monitor services for 2 of 51 Case Managers. **When the Case Managers were asked, what is your Agency's system to ensure timelines are met for Budget approval, the following was reported:** • #539 stated, "For budget approvals, I contact the provider and I add them to the budget. I have my supervisor review it and submit it to DDSD…Through the Medicaid Portal? I'm not too sure." **When the Case Managers were asked, what steps do you take when you identify an issue or concern regarding an Individual's health and safety / healthcare needs, the following was reported:** • #539 stated, "If it was onsite and I see something, I would call my boss. I don't know if I'm comfortable making that decision so I would get guidance from her…If I was able to, I would mitigate it at the site. I would report it. I would just call my boss and she would make the report." **When the Case Manager was asked to give examples of Abuse, Neglect and Exploitation, the following was reported:** • #529 stated for Abuse – "Someone refusing to provide dinner, DSP at the house not cooking tonight and figure it out yourself."	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Chapter 17: Training Requirements: 17.2 Training Requirements for CMs and Case Management Supervisors: Individual Specific Training: Complete IST requirements in accordance with the specifications described in the ISP of each person supported**…** 2. CM and CM Supervisors shall also complete DDSD-approved core curriculum training facilitated by certified trainers… 3. Substitute CMs shall comply with the training requirements of the CM for whom they are substituting. 4. All case managers will be required to complete 14 hours of training annually. a. ANE (Abuse, Neglect, and Exploitation) Awareness training is required annually and can be used towards the 14 hours for annual training. b. Training must include topic areas in health and person-centered planning related to health care for people with IDD. c. Remaining hours to be self-selected from list of DDSD approved providers of training, related to a person with IDD. Participation in pilot programs, meetings, webinars, or community of practice meetings approved or sponsored by DDSD can be used toward annual requirement. **Chapter 18: Incident Management System: 18.1 Training on Abuse, Neglect, and Exploitation (ANE) Recognition and Reporting:** All employees, contractors, volunteers, interns shall be trained on the ANE training curriculum approved by DOH. Employees or volunteers can work with a DD Waiver participant prior to receiving the training only if directly supervised, at all times, by a trained staff.			

Tag # 1A26 Employee Abuse Registry	Standard Level Deficiency		
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 55 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** • #520 – Date of hire 11/18/2022, completed 11/22/2022.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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

Tag # 1A27.0 Immediate Action and Safety Plan	Standard Level Deficiency		
NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS: C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications: **(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall: **(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable; **(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 **(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. Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 18: Incident Management System: 18.3 Immediate Action and Safety Plans (IASP):** Upon discovery of any alleged incident of ANE, the DD Waiver Provider Agency shall: 1. develop an Immediate Action and Safety Plans (IASP) for potentially endangered individuals; 2. be immediately prepared to report the IASP verbally to the DHI during the reporting of the initial allegation;	Based on interview, the Case Management Agency was not aware they are to receive the Immediate Action and Safety Plans (IASP) from providers and distribute to the IDT for 8 of 51 Individuals. **When the Case Manager was asked, what is your role in the IASP process, the following was reported:** • #507 did not indicate they are required to receive copies from the provider agency and the CM will distribute to the IDT. • #510 did not indicate they are required to receive copies from the provider agency and the CM will distribute to the IDT. • #517 did not indicate they are required to receive copies from the provider agency and the CM will distribute to the IDT. • #521 stated, "Yes the provider agency will send me their plan however, they did not indicate they are required to distribute to the IDT. • #528 did not indicate they are required to receive copies from the provider agency and the CM will distribute to the IDT. • #529 stated, "Sometimes. If I receive the IASP then I attempt to ensure they are following it as agreed to. #529 did not indicate they are required to receive copies from the provider agency and the CM will distribute to the IDT.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

3. report the IASP in writing on the DHI- issued IASP form within 24 hours; 4. revise the plan according to the DHI's direction, if necessary; 5. Send the IASP to the Case Manager; 6. closely follow and not change or deviate from the accepted IASP, without approval from the DHI.	• #547 did not indicate they are required to receive copies from the provider agency and the CM will distribute to the IDT. • #549 did not indicate they are required to receive copies from the provider agency and the CM will distribute to the IDT.		

Tag # 1A28.4 Incident Mgt: Case Manager Knowledge of IMB Notification Responsibility	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 18: Incident Management System: 18.8 Case Management and DD Waiver Provider Agency Responsibilities for Risk Management:** DD Waiver Provider Agencies have a continuous responsibility to monitor for risk of harm especially during and after an investigation… 1. In situations where DHI substantiates the ANE report, the CM must: a. Convene the DD Waiver participant's IDT to review the DHI findings detailed in the DHI issued *Decision Letter: Substantiated*; b. Modify the person's ISP, if necessary, to address any concerns identified in the investigation; and c. Submit the IDT meeting minutes with a signature page to DHI within 10 business days of receiving the Decision Letter.- i. The IDT meeting minutes must address all the concerns identified in the IMB Decision letter. ii. If the IDT already met and addressed all the concerns identified in the letter, there is no need to hold another meeting. If the IDT meeting did not address all concerns identified, then the CM may need to hold another IDT meeting. 2. At any time, in situations where a person is at significant risk of harm, the CM must convene the IDT within one working day, in person or by teleconference, and modify the ISP, if necessary, within 72-hours.	Based on interview, the Agency did not ensure case managers followed incident management procedures as required by standards for 2 of 51 case managers. **When the Case Manager was asked, what steps are you required to take if there is a substantiated allegation of Abuse, Neglect and Exploitation, the following was reported:** • #501 stated, "Depending on the situation we will remove the individual immediately, I believe is 24 hours." Per standards DHI substantiates the ANE report the Case Manager must 1) convene an IDT to review the DHI findings; 2) Modify the ISP if necessary; 3) submit IDT meeting minutes to DHI. • #528 stated, "They get fired the person who works with him, fire that staff, as a team we get together as soon as we can someone else." *QMB Surveyor asked: any other steps?* "No not really, never had any." Per standards DHI substantiates the ANE report the Case Manager must 1) convene an IDT to review the DHI findings; 2) Modify the ISP if necessary; 3) submit IDT meeting minutes to DHI.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Completion Date
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Standard Level Deficiency**		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **8.2.7 Monitoring and Evaluating Service Delivery:** The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health, safety and abuse free environment of the person. Monitoring and evaluation activities include the following requirements: … **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… **20.5.4 *Health Tracking:*** Health Tracking in Therap contains multiple requirements that support the Healthcare Coordinator, DSP, supervisors, nurses, CMs in tracking, communicating, and acting upon changes in health status…	Based on record review, the Agency did not maintain a complete client record at the administrative office for 5 of 100 individuals. Review of the Agency individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Nutritional Evaluation:** • Individual #1 - As indicated by the documentation reviewed, the evaluation is applicable to the Individual. No documented evidence of the evaluation being completed was found. • Individual #51 - As indicated by the documentation reviewed, the evaluation is applicable to the Individual. No documented evidence of the evaluation being completed was found. • Individual #65 - As indicated by the documentation reviewed, the evaluation is applicable to the Individual. No documented evidence of the evaluation being completed was found. • Individual #97 - As indicated by the documentation reviewed, the evaluation is applicable to the Individual. No documented evidence of the evaluation being completed was found. **Colonoscopy:**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

	• Individual #75 - As indicated by the documentation reviewed, the exam is applicable to the Individual. No documented evidence of the exam being completed was found.		

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Standard Level Deficiency		
Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 8: Case Management: 8.2.8 Maintaining a Complete Client Record:** The CM is required to maintain documentation for each person supported according to the following requirements: …. 3. The case file must contain the documents identified in Appendix A:Client File Matrix. **8.2.7 Monitoring and Evaluating Service Delivery:** The CM is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. The CM is also responsible for monitoring the health, safety and abuse free environment of the person. Monitoring and evaluation activities include the following requirements: … **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…	Based on record review, the Agency did not maintain a complete client record at the administrative office for 2 of 100 individuals. Review of the Agency individual case files revealed the following items were not found, not current and/or did not meet the requirement: **Electronic Comprehensive Health Assessment Tool *(eCHAT) Summary:*** • Not Found (#73, 95) **Aspiration Risk Screening Tool (ARST):** • Not Found (#73)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag #1A12 All Services Reimbursement	**No Deficient Practices Found**		
NMAC 8.302.2 BILLING FOR MEDICAID SERVICES Developmental Disabilities Waiver Service Standards Eff 11/1/2023 rev. 12/2023 **Chapter 21: Billing Requirements; 23.1 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and 3. Details of the services provided. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer…	Based on record review, the Agency maintained all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving case management for 100 of 100 individuals. *Progress notes and billing records supported Case Management billing activities for the months of December 2023, January and February 2024.*		

21.7 Billable Activities: Specific billable activities are defined in the scope of work and service requirements for each DD Waiver service. In addition, any billable activity must also be consistent with the person's approved ISP. **21.9 Billable Units**: The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit, or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days. 2. Face-to-face billable services shall be provided during a month where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit.			

Date: July 12, 2024

To: Sarah Martinez, Executive Director

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

E-mail Address: smartinez@nmddwcm.com

Region: Metro, Northeast, Northwest, Southeast, and Southwest
Survey Date: March 25 – April 9, 2024

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: Case Management

Survey Type: Routine

Dear Ms. Martinez:

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete.

Furthermore, your agency is now determined to be in Compliance with all Conditions of Participation.

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

Consistent use of these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Monica Valdez, BS

Monica Valdez, BS
Healthcare Surveyor Advanced/Plan of Correction Coordinator
DHI - Quality Management Bureau