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Secretary

DEPARTMENT OF

Building a Healthy New Mexico!

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Deputy Secretary

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Deputy Secretary

Karen Armitage, MD
Chief Medical Officer

Date: May 27, 2009

To: Carol Romero, Executive Director
 Provider: Advocacy Partners, LLC
 Address: 3100 Carlisle, Suite C
 State/Zip: Albuquerque, New Mexico 87110

E-mail Address: eromero77@hotmail.com.

Region: Metro
 Survey Date: April 7 – 15, 2009
 Program Surveyed: Developmental Disabilities Waiver
 Service Surveyed: Community Living (Family Living) & Community Inclusion (Community Access)
 Survey Type: Routine
 Team Leader: Stephanie R. Martinez de Berenger, MPA, GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
 Team Members: Florie Alire, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
 Survey #: Q09.04.13986007.METRO.001.RTN.01

Dear Mrs. Romero,

The Division of Health Improvement Quality Management Bureau has completed a quality review 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.

Quality Management Approval Rating:

The Division of Health Improvement is pleased to grant your agency a “MERIT” certification for compliance with DDSD Standards and regulations.

Plan of Correction:

The attached Report of Findings identifies deficiencies found during your agency’s survey. You are required to complete and implement a Plan of Correction (POC). Please submit your agency’s Plan of Correction (POC) in the space on the two right columns of the Report of Findings. See attachment A for additional guidance in completing the POC. The response is due to the parties below within 10 working days of the receipt of this letter:

1. Quality Management Bureau, Attention: Plan of Correction Coordinator
5301 Central Ave. NE Suite 900 Albuquerque, NM 87108
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 within 45 working days. If your plan of correction is denied, you must resubmit a revised plan ASAP for approval. All remedies must still be completed within 45 working days of the original submission.

Failure to submit, complete or implement your POC within the required time frames will result in the imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Request for Informal Reconsideration of Findings (IRF):

If you disagree with a determination of noncompliance (finding) you have 10 working days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

QMB Deputy Bureau Chief
5301 Central Ave NE Suite #900
Albuquerque, NM 87108
Attention: IRF request

A request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 working days. Providers may not appeal the nature or interpretation of the standard or regulation, the team composition, sampling methodology or the Scope and Severity of the finding.

If the IRF approves the change or removal of a finding, you will be advised of any changes.

This IRF process is separate and apart from the Informal Dispute Resolution (IDR) and Fair Hearing Process for Sanctions from DOH.

Please call the Team Leader at 505-222-8641, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,



Stephanie R. Martinez de Berenger, MPA, GCDF
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: April 7, 2009

Present: **Advocacy Partners, LLC**
Elena Romero Yamato, Service Coordinator/Trainer
Victoria Romero Knell, Service Coordinator/Finance

DOH/DHI/QMB
Stephanie R. Martinez de Berenger, MPA, GCDF,
Team Lead/Healthcare Surveyor
Florie Alire, RN, Healthcare Surveyor

Exit Conference Date: April 9, 2009

Present: **Advocacy Partners, LLC**
Carol Romero, Executive Director/Service Coordinator
Elena Romero Yamato, Service Coordinator/Trainer
Victoria Romero Knell, Service Coordinator/Finance
Venessa Rael, Records Management
Joanna Moya, Records Management

DOH/DHI/QMB
Stephanie R. Martinez de Berenger, MPA, GCDF,
Team Lead/Healthcare Surveyor
Florie Alire, RN, Healthcare Surveyor

Homes Visited

Number: 5

Administrative Locations Visited Number: 1

Total Sample Size Number: 5
0 - Jackson Class Members
5 - Non Jackson Class Members
5 - Family Living
2 - Community Access

Persons Served Interviewed Number: 5

Persons Served Observed Number: 5

Records Reviewed (Persons Served) Number: 5

Administrative Files Reviewed

- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes
- Nursing personnel files
- Evacuation Drills
- Quality Improvement/Quality Assurance Plan

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

Attachment A

DHI Quality Review Survey Report – Advocacy Partners, LLC, Metro Region – April 7 – 15, 2009

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Report #: Q09.04.13986007.METRO.001.RTN.01

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8624.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency (“Responsible Party”), and by WHEN (“Date Due”).
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency’s Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-841-5815), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been “Approved” or “Denied”.
- Whether your POC is “Approved” or “Denied”, you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is “Denied” it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- The following Deficiencies must be corrected within the deadlines below (after receipt of your Survey Report):
 - CCHS and EAR: 10 working days
 - Medication errors: 10 working days
 - IMS system/training: 20 working days
 - ISP related documentation: 30 working days
 - DDSD Training 45 working days
- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8624 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.

- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Attachment B

QMB Scope and Severity Matrix of survey results

Each deficiency in your Report of Findings is scored on a Scope and Severity Scale. The culmination of each deficiency's Scope and Severity is used to determine degree of compliance to standards and regulations and level of QMB Certification.

			SCOPE		
			Isolated 01% - 15%	Pattern 16% - 79%	Widespread 80% - 100%
SEVERITY	High Impact	Immediate Jeopardy to individual health and or safety	J.	K.	L.
		Actual harm	G.	H.	I.
	Medium Impact	No Actual Harm Potential for more than minimal harm	D.	E.	F. (3 or more)
			D. (2 or less)		F. (no conditions of participation)
	Low Impact	No Actual Harm Minimal potential for harm.	A.	B.	C.

Scope and Severity Definitions:

Key to Scope scale:

Isolated:

A deficiency that is limited to 1% to 15% of the sample, usually impacting no more than one or two individuals in the sample.

Pattern:

A deficiency that impacts a number or group of individuals from 16% to 79% of the sample is defined as a pattern finding. Pattern findings suggest the need for system wide corrective actions.

Widespread:

A deficiency that impacts most or all (80% to 100%) of the individuals in the sample is defined as widespread or pervasive. Widespread findings suggest the need for system wide corrective actions as well as the need to implement a Continuous Quality Improvement process to improve or build infrastructure. Widespread findings must be referred to the Internal Review Committee for review and possible actions or sanctions.

Key to Severity scale:

Low Impact Severity: (Blue)

Low level findings have no or minimal potential for harm to an individual. Providers that have no findings above a “C” level may receive a “Quality” Certification approval rating from QMB.

Medium Impact Severity: (Tan)

Medium level findings have a potential for harm to an individual. Providers that have no findings above a “F” level and/or no more than two F level findings and no F level Conditions of Participation may receive a “Merit” Certification approval rating from QMB.

High Impact Severity: (Green or Yellow)

High level findings are when harm to an individual has occurred. Providers that have no findings above “I” level may only receive a “Standard” Approval rating from QMB and will be referred to the IRC.

High Impact Severity: (Yellow)

“J, K, and L” Level findings:

This is a finding of Immediate Jeopardy. If a provider is found to have “I” level findings or higher, with an outcome of Immediate Jeopardy, including repeat findings or Conditions of Participation they will be referred to the Internal Review Committee.

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

Introduction:

Throughout the process, surveyors are openly communicating with providers. Open communication means that surveyors have clarified issues and/or requested missing information before completing the review. Regardless, there may still be instances where the provider disagrees with a specific finding.

To informally dispute a finding the provider must request in writing an Informal Reconsideration of the Finding (IRF) to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.

The written request for an IRF must be completed on the **QMB Request for Informal Reconsideration of Finding Form** (available on the QMB website) and must specify in detail the request for reconsideration and why the finding is inaccurate. **The IRF request must include all supporting documentation or evidence that was not previously reviewed during the survey process.**

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received in 10 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 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 Scope and Severity of a finding.
- 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 QMB Quality Approval Rating and the length of their DDSD provider contract.

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

QMB has 30 working days to complete the review and notify the provider of the decision. The request will be reviewed by the IRF committee. 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 successfully reconsidered, it will be noted and will be removed or modified from the report. 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.

Administrative Review Process:

If a Provider desires to challenge the decision of the IRF committee they may request an Administrative Review by the DHI and DDSD Director. The Request must be made in writing to the QMB Bureau Chief and received within 5 days of notification from the IRF decision.

Regarding IRC Sanctions:

The Informal Reconsideration of the Finding process is a separate process specific to QMB Survey Findings and should not be confused with any process associated with IRC Sanctions.

If a Provider desires to Dispute or Appeal an IRC Sanction that is a separate and different process. Providers may choose the Informal Dispute Resolution Process or the Formal Medicaid Fair Hearing Process to dispute or appeal IRC sanctions, please refer to the DOH Sanction policy and section 39 of the provider contract agreement.

Agency: Advocacy Partners, LLC – Metro Region
Program: Developmental Disabilities Waiver
Service: Community Living (Family Living) & Community Inclusion (Community Access)
Monitoring Type: Routine
Date of Survey: April 7 – 15, 2009

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A03 CQI System	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS I. Continuous Quality Management System: Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current	Based on record review, the Agency failed to develop and implement a Continuous Quality Management System. The copy of the Agency's Factor III-Quality Improvement Plan provided by the agency did not contain all components required by DD Waiver Standards.		

<p>Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to:</p> <ol style="list-style-type: none"> (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. 	<p>The Agency's CQI Plan did not contain the following components:</p> <ol style="list-style-type: none"> (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; 		
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Tag# 1A07 SSI Payments	Scope and Severity Rating: C		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY</p> <p>Requirements: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>C. Provider Agency Financial Records and Accounting: Each individual served will be presumed able to manage his or her own funds unless the ISP documents justified limitations or supports for self-management, and where appropriate, reflects a plan to increase this skill.</p>	<p>Based on record review and interview, the Agency failed to maintain and enforce written policies and procedures regarding the use of individuals' SSI payments or other personal funds.</p> <p>Review of the Agency's Policies and Procedures found no evidence of written a policy regarding individual SSI payments or other personal funds.</p> <p>When #49 was specifically asked if the Agency had policies and procedures regarding the use of individuals' SSI payments or other personal funds, the following was reported:</p> <p>#49 stated, "No, currently we do not have policies and procedures regarding the use of individuals' SSI payments or other personal funds."</p>		

<p>All Provider Agencies shall maintain and enforce written policies and procedures regarding the use of the individual's SSI payments or other personal funds, including accounting for all spending by the Provider Agency, and outlining protocols for fulfilling the responsibilities as representative payee if the agency is so designated for an individual.</p>			
<p>Tag # 1A09 Medication Delivery (MAR)</p>	<p>Scope and Severity Rating: E</p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD</p>	<p>Medication Administration Records (MAR) were reviewed for the months of December 2008, January and February, 2009.</p> <p>Based on record review 2 of 5 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #3 December 2008 Medication Administration Records did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose:</p> <ul style="list-style-type: none"> • Depakote 500mg (8PM) • Risperdal 2mg (bedtime) 		

<p>Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDS Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <p>(a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;</p> <p>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse</p>	<ul style="list-style-type: none"> • Diazepam 5mg (AM) • Diazepam 5mg (bedtime) • Citalopram 20mg (bedtime) <p>No specific “time taken” indicated on the Medication Administration Record for the following medication, MAR indicated time as “AM, PM and/or Bedtime”:</p> <ul style="list-style-type: none"> • Risperdal 2mg (bedtime) • Diazepam 5mg (AM) • Diazepam 5mg (bedtime) • Citalopram 20mg (bedtime) <p>January 2009 Medication Administration Records did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose:</p> <ul style="list-style-type: none"> • Depakote 500mg (8PM) • Risperdal 2mg (bedtime) • Diazepam 5mg (AM) • Diazepam 5mg (bedtime) • Citalopram 20mg (bedtime) <p>No specific “time taken” indicated on the Medication Administration Record for the following medication, MAR indicated time as “AM, PM and/or Bedtime”:</p> <ul style="list-style-type: none"> • Risperdal 2mg (bedtime) • Diazepam 5mg (AM) • Diazepam 5mg (bedtime) • Citalopram 20mg (bedtime) <p>February 2009 Medication Administration Records did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose:</p> <ul style="list-style-type: none"> • Protonix 40mg (8PM) • Diazepam 10mg (8PM) 		
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<p>events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. <p>Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner’s order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> ➤ symptoms that indicate the use of the medication, ➤ exact dosage to be used, and ➤ the exact amount to be used in a 24 hour 	<ul style="list-style-type: none"> • Celexa 10mg (8PM) • Celexa 20mg (8PM) • Depakote 500mg (8PM) <p>Individual #5 December 2008 Medication Administration Records did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose:</p> <ul style="list-style-type: none"> • Flovent 110 mcg (AM) • Flovent 110 mcg (PM) • Allegra 60 mg (AM) <p>No specific “time taken” indicated on the Medication Administration Record for the following medication, MAR indicated time as “AM, PM and/or Bedtime”:</p> <ul style="list-style-type: none"> • Flovent 110 mcg (AM) • Flovent 110 mcg (PM) • Allegra 60 mg (AM) <p>January 2009 Medication Administration Records did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose:</p> <ul style="list-style-type: none"> • Flovent 110 mcg (AM) • Flovent 110 mcg (PM) • Allegra 60 mg (AM) <p>No specific “time taken” indicated on the Medication Administration Record for the following medication, MAR indicated time as “AM, PM and/or Bedtime”:</p> <ul style="list-style-type: none"> • Flovent 110 mcg (AM) • Flovent 110 mcg (PM) • Allegra 60 mg (AM) <p>February 2009</p>		
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<p>period.</p>	<p>Medication Administration Records did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose:</p> <ul style="list-style-type: none"> • Flovent 110 mcg (AM) • Flovent 110 mcg (PM) • Allegra 60 mg (AM) <p>No specific “time taken” indicated on the Medication Administration Record for the following medication, MAR indicated time as “AM, PM and/or Bedtime”:</p> <ul style="list-style-type: none"> • Flovent 110 mcg (AM) • Flovent 110 mcg (PM) • Allegra 60 mg (AM) 		
<p>Tag # 1A12 Reimbursement/Billable Units</p>	<p>Scope and Severity Rating: B</p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p>B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed, which contained the required information for 4 of 5 individuals.</p> <p>Individual #1</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living for the month of December 2008. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. • The Agency billed 31 units of Family Living for the month of January 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. 		

<p>reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ol style="list-style-type: none"> (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. 	<ul style="list-style-type: none"> • The Agency billed 28 units of Family Living for the month of February 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. <p>Individual #2</p> <ul style="list-style-type: none"> • The Agency billed 31 units of Family Living for the month of December 2008. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. • The Agency billed 31 units of Family Living for the month of January 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. • The Agency billed 28 units of Family Living for the month of February 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. <p>Individual #3</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living for the month of February 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. <p>Individual #5</p> <ul style="list-style-type: none"> • The Agency billed 29 units of Family Living for the month of December 2008. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. • The Agency billed 27 units of Family Living for the month of January 2009. Documentation did not contain a signature/authenticated name of the staff providing the service to justify billing. 		
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Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 3 of 7 Direct Service Personnel.</p> <p>Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> • Person-Centered Planning (1-Day) (DSP #41 & 45) • First Aid (DSP #40, 41 & 45) • CPR (DSP #40, 41 & 45) • Rights & Advocacy (DSP #45) 		

<p>staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</p> <p>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</p>	<ul style="list-style-type: none"> • Teaching & Support Strategies (DSP #45) 		
<p>Tag # 1A25 (CoP) CCHS</p>		<p>Scope and Severity Rating: D</p>	
<p>NMAC 7.1.9.9 A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: A. homicide; B. trafficking, or trafficking in controlled substances; C. kidnapping, false imprisonment, aggravated assault or aggravated battery; D. rape, criminal sexual penetration, criminal</p>	<p>Based on record review, the Agency failed to maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 1 of 10 Agency Personnel.</p> <ul style="list-style-type: none"> • #48 – Date of hire 12/5/2005 		

<p>sexual contact, incest, indecent exposure, or other related felony sexual offenses; E. crimes involving adult abuse, neglect or financial exploitation; F. crimes involving child abuse or neglect; G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p> <p>Chapter 1.IV. General Provider Requirements. D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.</p>			
<p>Tag # 1A28 (CoP) Incident Mgt. System</p>	<p>Scope & Severity Rating: F</p>		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. B. Training Curriculum: The licensed health care facility and community based service provider shall provide all employees and volunteers with a written training curriculum on</p>	<p>Based on record review and interview, the Agency failed to establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement.</p> <p>During on site survey (April 7 – 15, 2009) review of policies and procedures found the agency had the DHI IMB policies and procedures for reporting incidences, however, the Agency did not have an Agency specific policy and procedure for Incident Management.</p> <p>When Executive Director/Service Coordinator (#49) was asked if the Agency had policies and procedures regarding incident management, the following was reported: #49 stated, "Informal process; however, incident</p>		

incident policies and procedures for identification, and timely reporting of abuse, neglect, misappropriation of consumers' property, and where applicable to community based service providers, unexpected deaths or other reportable incidents, within thirty (30) days of the employees' initial employment, and by annual review not to exceed twelve (12) month intervals. The training curriculum may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the licensed health care facilities or community based service provider's facility. Training shall be conducted in a language that is understood by the employee and volunteer.

C. Incident Management System Training Curriculum Requirements:

(1) The licensed health care facility and community based service provider shall conduct training, or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum that includes but is not limited to:

- (a) an overview of the potential risk of abuse, neglect, misappropriation of consumers' property;
- (b) informational procedures for properly filing the division's incident management report form;
- (c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and misappropriation of consumers' property.
- (d) specific instructions on how to respond to abuse, neglect, misappropriation of consumers' property;
- (e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, misappropriation of consumers' property; and
- (f) where applicable to employees of community based service providers, informational procedures for properly filing the division's incident management report form for unexpected

reporting will be included in agendas for weekly meeting.”

deaths or other reportable incidents.			
Tag # 1A31 (CoP) Client Rights	Scope and Severity Rating: F		
<p>NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:</p> <p>A. A service provider shall not restrict or limit a client's rights except:</p> <p>(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or</p> <p>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</p> <p>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</p> <p>B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention</p>	<p>Based on record review and interview, the Agency failed to adopt a written policy regarding a Human Rights Committee.</p> <p>During the on-site survey Surveyors requested the Agency's Human Rights Committee Meeting Minutes for any individuals who may have required an approval during April 2008 - April 2009. As of April 15th no documents were provided.</p> <p>Record review of the Agency found no evidence of the written HRC policy and procedure.</p> <p>When Executive Director/Service Coordinator (#49) was asked if the Agency had policies and procedures regarding Human Rights Committee, the following were reported:</p>		

necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider’s behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.
 C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights.
 [09/12/94; 01/15/97; Recompiled 10/31/01]

Long Term Services Division
Policy Title: Human Rights Committee
Requirements Eff Date: March 1, 2003

IV. POLICY STATEMENT

Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:

- Aversive Intervention Prohibitions
- Psychotropic Medications Use
- Behavioral Support Service Provision.

A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS

#49 stated, “No, we do not have a committee at this time. No we do not belong to a committee, we are exploring it”

<p>2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.</p>			
<p>Tag # 1A36 SC Training</p>	<p>Scope and Severity Rating: A</p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. C. Orientation and Training Requirements: Orientation and training for direct support</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 3 Service Coordinators.</p> <p>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</p> <ul style="list-style-type: none"> • Level 1 Health (SC #46) 		

<p>staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</p>			
<p>Tag # 5I36 CA Reimbursement</p>	<p>Scope and Severity Rating: A</p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS G. Reimbursement (1) Billable Unit: A billable unit is defined as one-quarter hour of service. (2) Billable Activities: The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan;</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed 1 of 2 individuals receiving Community Access Services.</p> <p>Individual #3</p> <ul style="list-style-type: none"> December 2008 Agency billed 184 units of Community Access. No documentation found to justify billing. January 2009 Agency billed 226 units of Community Access. No documentation found to justify billing. 		

<p>(b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and</p> <p>(c) Non face-to-face hours do not exceed 10% of the monthly billable hours.</p> <p>(3) Non-Billable Activities: Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:</p> <p>(a) Time and expense for training service personnel;</p> <p>(b) Supervision of agency staff;</p> <p>(c) Service documentation and billing activities; or</p> <p>(d) Time the individual spends in segregated facility-based settings activities.</p>			
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Tag # 6L14 Residential Case File	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:</p> <p>(1) Complete and current ISP and all supplemental plans specific to the individual;</p> <p>(2) Complete and current Health Assessment Tool;</p> <p>(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</p> <p>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 4 of 5 Individuals receiving Family Living Services.</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification (#2 & 4) • Annual ISP (#2 & 3) • ISP Signature Page (#2, 3 & 5) • Addendum A (#2, 3 & 5) • Individual Specific Training (Addendum B) (#2 & 3) • Positive Behavioral Plan (#3 & 4) • Positive Behavioral Crisis Plan(#3 & 4) • Speech Therapy Plan (#2) • Health Assessment Tool (#4 & 5) • Crisis Plan: <ul style="list-style-type: none"> ◦ Seizure Crisis Plan (#4) (Per ISP the individual is required to have a Seizure Crisis Plan) • Progress Notes/Daily Contacts Logs: <ul style="list-style-type: none"> ◦ None found from March 1 – 31, 2009 (#3) ◦ None found from April 1 – 8, 2009 (#3) • Data Collection/Data Tracking: <ul style="list-style-type: none"> ◦ None found from March 1 – 31, 2009 (#3) ◦ None found from April 1 – 8, 2009 (#3) 		

<p>response to identified changes in condition for at least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current</p>			
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ISP year; and
(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.