Date:	October 1, 2009
To:	Misty Torres, Executive Director
Provider:	Amor Para Todos
Address:	P.O. Box 1628
State/Zip:	Belen, New Mexico 87002
E-mail Address:	AMORPARATODOS@msn.com
Region:	Metro
Survey Date:	August 5 – 6, 2009
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Community Living (Family Living, Substitute Care & Respite)
Survey Type:	Focused
Team Leader:	Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Cynthia Nielsen, R. N. MSN., Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Barbara Czinger, LISW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Torres:

The Division of Health Improvement Quality Management Bureau has completed a focused survey of the service 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. The specific focus of the survey was to determine compliance with Personnel Training, Caregivers Criminal History Screening, Abuse Registry, and billing of the above identified services. Due to the significant non-compliance with DDSD Standards and regulations your agency will additionally be referred to the Internal Review Committee for review and possible sanction.

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 505-841-5831, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Marti Madrid, LBSW

Marti Madrid, LBSW
Team Lead/Health Care Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	August 5, 2009	
Present:	**Amor Para Todos** Misty Torres, Executive Director **DOH/DHI/QMB** Marti Madrid, LBSW, Team Lead/Healthcare Surveyor Cynthia Nielsen, RN, MSN, Healthcare Surveyor Barbara Czinger, MSW, LISW, Healthcare Surveyor	
Exit Conference Date:	August 6, 2009	
Present:	**Amor Para Todos** Misty Torres, Executive Director Janice Montano, RN/Service Coordinator **DOH/DHI/QMB** Marti Madrid, LBSW, Team Lead/Healthcare Surveyor Cynthia Nielsen, RN, MSN, Healthcare Surveyor Barbara Czinger, LISW, Healthcare Surveyor	
Homes Visited	Number:	1
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	15 4 - Jackson Class Members 11 - Non-Jackson Class Members 15 - Family Living 15 - Substitute Care 0 - Respite
Persons Served Interviewed	Number:	1
Records Reviewed (Persons Served)	Number:	15

Administrative Files Reviewed

- Billing Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Nursing personnel files

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

Attachment A

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

- 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		
SEVERITY			**Isolated 01% - 15%**	**Pattern 16% - 79%**	**Widespread 80% - 100%**
	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.

Attachment C

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: http://dhi.health.state.nm.us/qmb) 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: **Amor Para Todos - Metro Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Family Living, Substitute Care & Respite)
Monitoring Type: Focused Survey
Date of Survey: **August 5 – 6, 2009**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A11 (CoP) Transportation Training	**Scope and Severity Rating: D**		
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. **G. Transportation:** Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and procedures must address at least the following topics: (1) Drivers' requirements, (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (3) Vehicle maintenance and safety inspections, (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures,	Based on record review the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 3 of 37 Direct Service Personnel. No documented evidence was found of the following required training: • Transportation (DSP # 44, 48 & 52)		

(5) Emergency Plans, including vehicle evacuation techniques, (6) Documentation, and (7) Accident Procedures**.** **Department of Health (DOH)** **Developmental Disabilities Supports Division (DDSD) Policy** Training Requirements for Direct Service Agency Staff Policy **Eff Date:** March 1, 2007 **II. POLICY STATEMENTS:** I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)			

Tag # 1A12 Reimbursement/Billable Units	Scope and Severity Rating: C		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **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. **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 reimbursement from the HSD. For each unit billed, the record shall contain the following: (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. **NMAC 8.314.5.17 REIMBURSEMENT:** Waiver service providers must submit claims for reimbursement to the MAD Medicaid management information system (MMIS) contractor for processing. Claims must be filed per the billing instructions in the Medicaid policy manual. Providers must follow all Medicaid billing instructions. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of waiver services is made at a predetermined reimbursement rate.	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 15 of 15 individuals. Individual #1 May 2009 • The Agency billed 28 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. June 2009 • The Agency billed 28 units of Family Living from 6/1/2009 through 6/30/2009. Documentation did not contain a signature of the staff providing the service to justify billing. Individual #2 May 2009 • The Agency billed 31 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed 31 units of Family Living. Review of documentation indicated services were provided concurrently with Substitute Care on May 9 & 10, 2009, as Substitute Care was provided from ”12 AM to 12AM” for each day in question. • The Agency billed a total of 404 units of Substitute Care on May 1, 3, 5, 6, 7, 8, 9, 10, 11 & 21, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. June 2009 • The Agency billed 29 units of Family Living from 6/1/2009 through 6/30/2009.		

MAD-MR: 03-59 Eff 1/1/2004 - 8.314 BI BILLING INSTRUCTIONS FOR THE DISABLED AND ELDERLY, MEDICALLY FRAGILE, HIV/AIDS AND DEVELOPMENTAL DISABILITIES WAIVERS **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. A. **Documentation Requirements:** Provider records must be sufficiently detailed to substantiate or document the following: (1) The type of health service billed; (2) The medical necessity of any service furnished which includes the substantiation of any diagnosis made during the service; (3) The results of services furnished including, if applicable, laboratory and radiology procedures; and (4) The appropriate consent forms, if applicable. **B. Record Retention Requirements:** Providers who receive payment for treatment, services or goods from MAD must retain all medical and business records which relate to those payments for a period of five (5) years after the payment is received. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **Chapter 6 - COMMUNITY LIVING SERVICES** **III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **C. Service Limitations**. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support	Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 512 units of Substitute Care on June 16, 17, 18, 19, 20, 21, 22, 26 & 27, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #3 May 2009 • The Agency billed 31 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 348 units of Substitute Care on May 1, 3, 6, 7, 9, 12, 14, 16, 28, 30 & 31, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. June 2009 • The Agency billed 29 units of Family Living from 6/1/2009 through 6/30/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 304 units of Substitute Care on June 6, 13, 16, 19, 20, 23, 25, 26, 28 & 30, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #4 May 2009 • The Agency billed 30 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of		

Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore, a specified deduction to the daily rate for Family Living shall be made for each unit of respite received. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **DEFINITIONS** **SUBSTITUTE CARE** means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider. **RESPITE** means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.	the staff providing the service to justify billing. • The Agency billed a total of 350 units of Substitute Care on May 1, 2, 3, 15, 16, 19, 20 & 21, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. June 2009 • The Agency billed 27 units of Family Living from 6/1/2009 through 6/30/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 332 units of Substitute Care on June 1, 4, 6, 10, 13, 14, 15, 19, 20, 21 & 28, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #5 May 2009 • The Agency billed 28 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed 28 units of Family Living. Review of documentation indicated services were provided concurrently with Substitute Care on May 3 & 4, 2009, as Substitute Care was provided from ”12 AM to 12AM” for each day in question. • The Agency billed a total of 332 units of Substitute Care on May 1, 2, 3, 4 & 5, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing.		

	June 2009 • The Agency billed 28 units of Family Living from 6/1/2009 through 6/30/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed 28 units of Family Living. Review of documentation indicated services were provided concurrently with Substitute Care on June 6 & 7, 2009, as Substitute Care was provided from ”12 AM to 12AM” for each day in question. • The Agency billed a total of 332 units of Substitute Care on June 5, 6, 7, 8, 20 & 21, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #6 May 2009 • The Agency billed 28 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed 28 units of Family Living. Review of documentation indicated services were provided concurrently with Substitute Care on May 2, 3, 10, 23 & 24, 2009, as Substitute Care was provided from ”12 AM to 12AM” for each day in question. • The Agency billed a total of 596 units of Substitute Care on May 1, 2, 3, 4, 9, 10, 11, 22, 23, 24 & 25, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. June 2009 • The Agency billed 28 units of Family Living		

	from 6/1/2009 through 6/30/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 180 units of Substitute Care on June 28, 29 & 30, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #7 May 2009 • The Agency billed 28 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 120 units of Substitute Care on May 9 & 10, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. June 2009 • The Agency billed 28 units of Family Living from 6/1/2009 through 6/30/2009. Documentation did not contain a signature of the staff providing the service to justify billing. Individual #8 May 2009 • The Agency billed 28 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 256 units of Substitute Care on May 28, 29, 30 & 31, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing.		

	• The Agency billed 256 units of Substitute Care. Documentation received accounted for 236 units. June 2009 • The Agency billed 28 units of Family Living from 6/1/2009 through 6/30/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 576 units of Substitute Care on June 18, 19, 20, 21, 22, 25, 26, 27 & 28, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #9 May 2009 • The Agency billed 28 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 384 units of Substitute Care on May 3, 9, 14, 16, 17, 18, 22, 23, 24, 27 & 28, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. June 2009 • The Agency billed a total of 440 units of Substitute Care on June 6, 7, 12, 14, 19, 20, 21, 22, 23, 25, 26 & 28, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #10 May 2009 • The Agency billed 28 units of Family Living		

	from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service for each daily unit billed to justify billing. Documentation contained only one signature for every seven days of progress notes. • The Agency billed 28 units of Family Living. Review of documentation indicated services were provided concurrently with Substitute Care on May 9 &10, 2009, as Substitute Care was provided from ”12 AM to 12AM” for each day in question. • The Agency billed a total of 332 units of Substitute Care on May 6, 7, 8, 9 & 10, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. June 2009 • The Agency billed a total of 332 units of Substitute Care on June 1, 2, 5, 6, 7 & 8, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. • The Agency billed 332 units of Substitute Care. Documentation received accounted for 304 units. Individual #11 May 2009 • The Agency billed 29 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed 29 units of Family Living. Review of documentation indicated services were provided concurrently with Substitute Care on May 7, 8, 9 &10, 2009, as Substitute		

	Care was provided from ”12 AM to 12AM” for each day in question. • The Agency billed a total of 520 units of Substitute Care from May 3, 6, 7 & 8, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Documentation received accounted for 258 units. • The Agency billed a total of 264 units of Substitute Care on May 9, 10 & 11, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. June 2009 • The Agency billed a total of 474 units of Substitute Care on June 23, 24, 25, 26, 27 & 28, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #12 May 2009 • The Agency billed 28 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 322 units of Substitute Care on May 8, 9, 10, 14, 20, 21, 22 & 25, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. June 2009 • The Agency billed 28 units of Family Living from 6/1/2009 through 6/30/2009. Documentation did not contain a signature of the staff providing the service to justify billing.		

	• The Agency billed a total of 336 units of Substitute Care on June 2, 3, 5, 6, 7, 9, 10, 12, 13 & 15, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #13 May 2009 • The Agency billed 28 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 352 units of Substitute Care on May 2, 3, 9, 16, 17, 23, 24 & 30, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. June 2009 • The Agency billed 28 units of Family Living from 6/1/2009 through 6/30/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 312 units of Substitute Care on June 6, 7, 14, 19, 28, 29 & 30, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #14 May 2009 • The Agency billed 29 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed 29 units of Family Living. Review of documentation indicated services were provided concurrently with Substitute Care on May 15, 16 & 17, 2009, as Substitute		

	Care was provided from ”12 AM to 12AM” for each day in question. • The Agency billed a total of 300 units of Substitute Care on May 14, 15, 16, 17 & 18, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. June 2009 • The Agency billed 27 units of Family Living from 6/1/2009 through 6/30/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 332 units of Substitute Care on June 11, 12, 13, 14 & 15, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing. Individual #15 May 2009 • The Agency billed 28 units of Family Living from 5/1/2009 through 5/31/2009. Documentation did not contain a signature of the staff providing the service to justify billing. • The Agency billed a total of 696 units of Substitute Care on May 1, 2, 3, 5, 9, 16, 17, 18, 22, 23, 24 & 25, 2009. Documentation did not contain a description of what occurred during the encounter or service interval to justify billing.		

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: D		
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 staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (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 (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.	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 3 of 37 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #43 & 50) • Basic Health/Orientation (DSP #50) • Person-Centered Planning (1-Day) (DSP #41) • Rights & Advocacy (DSP #43) • Level 1 Health (DSP #50) • Teaching & Support Strategies (DSP # 41 & 50)		

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: D		
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. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.	Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 2 of 37 Agency Personnel. • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#41 & 70)		

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: E		
NMAC **7.26.5.16.C and D** **Development of the ISP. Implementation of the ISP.** The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with	Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 5 of 15 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #2 • None found for May 2009 regarding: 'Wanting to become a photographer.' Individual #4 • None found for May 2009 regarding: 'Purchasing a patio set by looking for a patio set one time weekly.' • None found for May 2009 regarding: 'Going on vacation.' Individual #7 • None found for May 2009 regarding: 'Will go camping and do hiking and fishing by save money for camping trip one time monthly.' Individual #8 • None found for July 2009 regarding: 'Going to movie theatre one time monthly.' Individual #12 • None found for May 2009 regarding: 'Socializing with AV in community setting.' • None found for June 2009 regarding: 'Socializing with AV in community setting.'		

developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	• None found for July 2009 regarding: 'Socializing with AV in community setting.'		

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **B. Home Studies**. The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS** **D. Scope of DDSD Agreement** (4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite; **NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER** **ELIGIBLE PROVIDERS:** I. **Qualifications for community living service providers:** There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards.	Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 2 of 15 individuals. The following was not found, not current and/or incomplete: • Family Living (Annual Update) Home Study (#11 & 12)		

(1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.			

Tag # 12R01 Substitute Care & Respite Provide Staffing Requirements	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 12 RESPITE SERVICES IV. RESPITE SERVICES PROVIDER AGENCY STAFFING REQUIREMENTS** **B. Staffing Requirements:** **(1) Staff Qualifications** a) Direct Support Staff are required to complete a minimum of forty (40) hour initial training program. The required training is outlined in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities. b) Direct Support Staff are required to also participate in ongoing training at a minimum of ten (10) hours per year after the first year. c) Direct Support Staff are required to have current CPR and First Aid agreement. d) Complete individual-specific training as outlined in the ISP for individuals they serve. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy T-003** **Policy Title:** Training Requirements for Direct Service Agency Staff Policy eff. 3/1/2007 B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 3 of 37 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • First Aid (DSP #65 & 66) • CPR (DSP #65 & 66) • Assisting With Medications (DSP #70)		

D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines. F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001. J. Respite, substitute care, and personal support staff shall complete a minimum of 40 hours of training within the first year of assignment. Thereafter, they shall complete a minimum of 10 hours per year. Specific courses shall include: 1. Applicable requirements described in policy statements B – I (above). 2. Agency-specific course requirements (which may include core curriculum trainings). 3. The maximum number of individual-specific training hours outside of a formal classroom setting that can be applied to the 40-hour requirement is eight (8). 4. The maximum number of individual-specific training hours outside of a formal classroom setting that can be applied to the 10-hour requirement is four (4).			