Date:	March 16, 2011
To:	Paul Farren, Executive Director
Provider:	Grace Requires Understanding, Inc.
Address:	125 West Mountain Ave.
State/Zip:	Las Cruces, NM 88005
E-mail Address:	pfarren@mygru.org
CC:	Victor Duran, Board Chair
Address:	P. O. Box 2334
State/Zip:	Mesilla Park, NM 88047
E-Mail Address:	victord3@msn.com
Region:	Southwest
Routine Survey:	May 24 – June 1, 2010
Verification Survey:	February 15 - 16, 2011
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Community Living (Family Living & Independent Living &) & Community Inclusion (Adult Habilitation & Community Access)
Survey Type:	Verification
Team Leader:	Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Valerie V. Valdez, MS, Healthcare Program Manager, Division of Health Improvement/Quality Management Bureau

Dear Mr. Farren,

The Division of Health Improvement/Quality Management Bureau has completed a verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI/DDSD regarding the Routine Survey on May 24 – June 1, 2010.

These findings will be reviewed by the DOH – Internal Review Committee during an upcoming review meeting. The findings are attached. You will be contacted by the Department for further instructions regarding your plan of correction requirements.

Please call the Plan of Correction Coordinator at 505-222-8647, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Deb Russell, BS

Deb Russell, BS
Team Lead/Healthcare Surveyor
Division of Health Improvement/Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	February 15, 2011
Present:	**Grace Requires Understanding, Inc.** Mark Chavez, General Manager Paul Farren, Executive Director **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor Valerie V. Valdez, MS, Program Manager/Healthcare Surveyor
Exit Conference Date:	February 16, 2011
Present:	**Grace Requires Understanding, Inc.** Mark Chavez, General Manager Paul Farren, Executive Director **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor Valerie V. Valdez, MS, Program Manager/ Healthcare Surveyor
Homes Visited	Number: 4
❖ Family Homes Visited	Number: 4
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 20 0 - Jackson Class Members 20 - Non-Jackson Class Members 19 - Family Living 1 – Independent Living 2 - Adult Habilitation 7 - Community Access
Persons Served Interviewed	Number: 20 individuals required no direct interview/observation as part of the verification survey.
Records Reviewed (Persons Served)	Number: 20
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 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 Findings:

"Substantial Compliance with Conditions of Participation"
The QMB determination of "Substantial Compliance with Conditions of Participation" indicates that a provider is in substantial compliance with all 'Conditions of Participation' and other standards and regulations. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Substantial Compliance with Conditions of Participation, the provider must not have any findings that meet the thresholds for determining non-compliance with any Condition of Participation.

"Non-Compliance with Conditions of Participation"
The QMB determination of "Non-Compliance with Conditions of Participation" indicates that a provider is out of compliance with one (1) or more 'Conditions of Participation.' This non-compliance, if not corrected, is likely to result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety.

Providers receiving a repeat determination of Non-Compliance may be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

"Sub-Standard Compliance with Conditions of Participation":
The QMB determination of "Sub-Standard Compliance with Conditions of Participation" indicates a provider is significantly out of compliance with Conditions of Participation and/or has:

Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm. Any finding of actual harm or Immediate Jeopardy.

Providers receiving a repeat determination of 'Substandard Compliance' will be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

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.

Agency: **Grace Requires Understanding, Inc. - Southwest Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Family Living & Independent Living) & Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Verification Survey
Routine Survey: **May 24 – June 1, 2010**
Verification Survey: **February 15 - 16, 2011**

Statute	May 24 – June 1, 2010 Deficiencies	February 15 - 16, 2011 Verification Survey - New and Repeat Deficiencies
Tag # 1A11 (CoP) Transportation Training	**Scope and Severity Rating: E**	**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,	Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 85 of 164 Direct Service Personnel. No documented evidence was found of the following required training: • Transportation (DSP #41, 43, 44, 45, 48, 49,51, 54, 55, 59, 60, 62, 63, 66, 67, 69, 75, 77, 81, 84, 86, 90, 91, 92, 93, 97, 101, 102, 105, 109, 111, 112,113, 114, 116, 117, 118, 119, 120, 128, 136, 137, 141, 144, 145, 150, 151, 159, 160, 162, 163, 166, 167, 168, 170, 171, 172, 174, 175, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201 & 202) When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported: DSP #42 stated, "No. I trained myself"	**New & Repeat Finding:** Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 21 of 164 Direct Service Personnel. No documented evidence was found of the following required training: • Transportation (DSP #191, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 234, 235, 237, 241, 242, 243 & 244)

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, (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)	DSP#93 stated, "No, training from Agency." DSP#97 stated, "Not from Agency." DSP#154 stated, "No, not from Agency." DSP#156 stated, "No, not at any agency." DSP#165 stated, "No."	

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: NA	Scope and Severity Rating: D
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **A. Duty To Report:** **(1)** All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. **(2)** All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property**,** unexpected and natural/expected deaths; and other reportable incidents to include: **(a)** an environmental hazardous condition, which creates an immediate threat to life or health; or **(b)** admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider. **(3)** All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. **B. Notification**: **(1) Incident Reporting:** Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.		**New Finding:** Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 21 individuals. Individual #1 • Incident date 8/7/2010. Allegation was Emergency Services. Incident report was received 8/13/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was added and was "Confirmed."

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: E	Scope and 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. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007** **II. POLICY STATEMENTS:** 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 provide documentation verifying completion of Incident Management Training for 54 of 172 Agency Personnel. • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#44, 45, 53, 55, 61, 73, 74, 77, 78, 83, 90, 94, 104, 105, 113, 114, 116, 117, 119, 125, 130, 131, 132, 133, 135, 139, 141, 144, 145, 157, 167,168, 174, 176, 182, 183, 186, 187, 189, 194, 195, 197, 199, 200, 202, 203, 205, 208, 209, 210, 211, 212, 213 & 214)	**Repeat Finding:** Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 1 of 177 Agency Personnel. • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#61)

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: E	Scope and Severity Rating: D
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 developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	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 7 of 20 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 #16 • None found for 1/2010 **Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #20 • No Outcomes/Action Plans or DDSD exemption/decision justification found for Independent Living Services. As indicated by NMAC 7.26.5.14 “Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.” **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #12 • No Outcomes/Action Plans or DDSD exemption/decision justification found for Adult Habilitation Services. As indicated by NMAC 7.26.5.14 “Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.”	**Repeat & New Finding:** 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 7 of 20 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #20 • None found for 11/2010

	Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes: Individual #3 • None found for 1/2010 – 4/2010 Individual #4 • None found for 1/2020 – 3/2010 . Individual #5 • None found for 1/2020 – 3/2010 . Individual #18 • No Outcomes/Action Plans or DDSD exemption found/decision justification found for Community Access Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver." .	

Statute	May 24 – June 1, 2010 Scope and Severity Ratings	February 15 - 16, 2011 Verification Survey Results
Tag # 1A08 Agency Case File	B	Completed
Tag # 1A08 Agency Case File - Progress Notes	A	Completed
Tag # 1A09 Medication Delivery (MAR) - Routine Medication	F	Completed
Tag # 1A09 Medication Delivery - PRN Medication	E	Completed
Tag # 1A15 Nurse Availability	D	Completed
Tag # 1A15 Healthcare Documentation	E	Completed
Tag # 1A20 DSP Training Documents	F	Completed
Tag # 1A22 Staff Competence	E	Completed
Tag # 1A25 (CoP) CCHS	D	Completed
Tag # 1A26 (CoP) COR / EAR	E	Completed
Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	D	Completed
Tag # 1A31 (CoP) Client Rights/Human Rights	D	Completed
Tag # 1A36 SC Training	B	Completed
Tag # 1A37 Individual Specific Training	E	Completed
Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	B	Completed
Tag # 5I36 CA Reimbursement	B	Completed
Tag # 6L06 (CoP) - FL Requirements	D	Completed
Tag # 6L14 Residential Case File	E	Completed
Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	A	Completed
Tag # 6L27 FL Reimbursement	C	Completed