

Date: May 13, 2010

To: Pamela Stafford, Executive Director
Provider: Connection, LLC
Address: 217 San Pedro NE
State/Zip: Albuquerque, New Mexico 87108

E-mail Address: pstafford@connectionsnm.com

Region: Metro
Survey Date: March 22 – 26, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
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 & Linda Clark, BA, Community Inclusion Coordinator, Developmental Disabilities Service Division.

Dear Ms. Stafford,

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 issuing your agency a finding of “NON-COMPLIANCE” for basic 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 400 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.



“Assuring safety and quality of care in New Mexico’s health facilities and community-based programs.”

David Rodriguez, Division Director • Division of Health Improvement

Quality Management Bureau • 5301 Central Ave. NE Suite 400 • Albuquerque, New Mexico 87108
(505) 222-8623 • FAX: (505) 222-8661 • <http://dhi.health.state.nm.us>

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 #400
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 505-690-7285, 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

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

Survey Process Employed:

Entrance Conference Date: March 22, 2010

Present: **Connection , LLC**
Aisle McGrath, Service Coordinator

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

DDSD - Metro Regional Office
Linda Clark, Community Inclusion Coordinator

Exit Conference Date: March 26, 2010

Present: **Connections, LLC**
Pamela Stafford, Executive Director
L. Matthew Bardwell, Director of Operations

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

DDSD - Metro Regional Office
Linda Clark, Community Inclusion Coordinator

Administrative Locations Visited Number: 1

Total Sample Size Number: 15
4- Jackson Class Members
11 - Non-Jackson Class Members
11- Adult Habilitation
5 - Supported Employment
5 - Community Access

Persons Served Interviewed Number: 10

Persons Served Observed Number: 5 (Five Individuals were not available during the on-site visit)

Records Reviewed (Persons Served) Number: 15

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
- Nursing personnel files
- 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

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 505-222-8647.
- 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 (505-222-8661), 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):
- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8647 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 numbers.
- 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.

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)		
	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:

“Compliance”

“Compliance” indicates that a provider is in compliance with all ‘Conditions of Participation’ and substantial compliance with 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 be in “Compliance” the provider must not have any findings that are a Condition of Participation.

“Partial Compliance”

“Substantial Compliance” also know as, “Partial Compliance” indicates a provider has obtained a minimum level of compliance, but still has isolated Conditions of Participation out of compliance. This isolated non-compliance if not corrected is a potential for more than minimal harm (scope/severity level “D”) to individuals’ health and safety. A provider in Substantial Compliance may have any number of “D” level Conditions of Participation out of compliance, but no Conditions higher than “D” level.

“Non-Compliance”

“Non-Compliance” indicates that a provider is out of compliance with one or more Conditions of Participation and/or other additional standards and regulations. This non-compliance if not corrected is a potential for more than minimal harm (scope/severity level “E” or “F”) to individuals’ health and safety.

Providers having repeat Non-compliance findings may be referred by QMB to the Internal Review Committee (IRC) for potential actions and sanctions, including but not limited to:

- Repeat findings of Conditions of Participation
- A pattern of repeat findings

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: Connection, LLC – Metro Region
Program: Developmental Disabilities Waiver
Service: Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Routine Survey
Date of Survey: March 22 - 26, 2010

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A03 CQI System	Scope and Severity Rating: C		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS</p> <p>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 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> <p>(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</p>	<p>Based on record review, the Agency failed to update and implement their Quality Assurance System Plan on an annual basis.</p> <p>The Agency's Quality Assurance System Plan provided during the on-site survey (March 22, 2010) was dated July 2005. No evidence was found indicating when the document had been updated.</p> <p>Review of the Agency's Quality Assurance System Plan provided during the on-site survey did not contain the components required by Standards.</p> <p>The Agency's CQI Plan did not contain the following components:</p> <p>(4) Trends in medication and medical incidents leading to adverse health events; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction</p>		

- supervisory and direct support levels;
- (6) Quality and completeness documentation; and
- (7) Trends in individual and guardian satisfaction.

7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:

E. Quality Improvement System for Community Based Service Providers: The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:

- (1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;
- (2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;
- (4) community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.

Tag # 1A05 (CoP) General Requirements	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>A. General Requirements:</p> <p>(2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDS policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.</p>	<p>Based on record review, the Agency failed to review and update its written policies and procedures every three years or as needed.</p> <p>The following policies and procedures provided during the on-site survey (March 22, 2010) showed no evidence of being reviewed every three years or being updated as needed:</p> <ul style="list-style-type: none"> • “Human Rights Committee” - Last reviewed July 2005. • “Abuse, Neglect & Exploitation” - Last revised July 2005. • “Evacuation Drills” - Last revised August 2005. • “On-Call Staffing” - Last revised July 2005. • “Transportation” - Last revised August 2005. 		

Tag # 1A08 Agency Case File	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <ol style="list-style-type: none"> (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the 	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 9 of 15 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Positive Behavioral Plan (#6) • Positive Behavioral Crisis Plan (#6) • Speech Therapy Plan (#6, 7 & 13) • Occupational Therapy Plan (#5 & 7) • Physical Therapy Plan (#5) • Transition Plan (#4) • Annual Physical (#3, 8, 11 &12) 		

<p>developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <ul style="list-style-type: none"> (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital. 			
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Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</p> <p>(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:</p> <ul style="list-style-type: none"> (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. <p>(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 5 of 15 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Health Assessment Tool (#4, 5, 9 & 11) • Medication Administration Assessment Tool (#4, 5 & 11) • Meal Time Plan <ul style="list-style-type: none"> ○ Individual #3- As indicated by the IST section of ISP the individual is required to have a plan. No plan was found. 		

<p>caregiver upon request.</p> <p>(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first.</p> <p>(d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy).</p> <p>(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as <i>subjective</i> information including the individual complaints, signs and symptoms noted by staff, family members or other team members; <i>objective</i> information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); <i>assessment</i> of the clinical status, and <i>plan</i> of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p>(2) Health related plans</p> <p>(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.</p>			
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<p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.</p> <p>(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.</p> <p>(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):</p> <p>(a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.</p> <p>(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.</p> <p>(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.</p>			
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<p>(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.</p> <p>(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.</p> <p>(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.</p> <p>(g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author.</p> <p>(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.</p> <p>(4) General Nursing Documentation</p> <p>(a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.</p> <p>(b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.</p>			
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Tag # 1A20 DSP Training Documents	Scope and Severity Rating: D	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>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 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:</p> <ol style="list-style-type: none"> (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. <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 2 of 17 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 #50) • Rights & Advocacy (DSP #51) 	

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.

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.

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.

Tag # 1A22 Staff Competence	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</p> <p>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>F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</p> <ol style="list-style-type: none"> (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy 	<p>Based on interview, the Agency failed to ensure that training competencies were met for 6 of 9 Direct Service Personnel.</p> <p>When DSP were asked if they received training on the Individual’s Positive Behavioral Supports Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #52 stated, “No, I have not received any training on the Positive Behavioral Therapy Plan. According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Plan. (Individual #5) • DSP #56 stated, “No, I am not aware of the Positive Behavioral Support Plan” According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Plan. (Individual #4) <p>When DSP were asked if they received training on the Individual’s Speech Therapy Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #41 stated, “No, I can not recall when I was trained on the Speech Therapy Plan.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #13) • DSP #47 stated, “No, I have not received Training on the Speech Therapy Plan.” According to the Individual Specific Training Section of the ISP, the individual requires a Speech Therapy Plan. (Individual #5) • DSP #52 stated, “No, I am unaware of a Speech Plan existing.” According to the Individual Specific Training Section of the ISP, the individual requires a Speech Therapy Plan. (Individual #9) 	

<p>Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and</p> <p>(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.</p> <p>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:</p> <p>(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p>	<ul style="list-style-type: none"> • DSP #52 stated, “No, I have not received Training on the Positive Behavioral Therapy Plan.” According to the Individual Specific Training Section of the ISP, the individual requires a Positive Behavioral Therapy Plan (Individual #5) • DSP #56 stated, “No, I am not aware of Speech Therapy Services or Plans.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan (Individual #4) <p>When DSP were asked if they received training on the Individual’s Occupational Therapy Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #40 stated, “No, I can’t recall if I was trained on the Occupational Therapy Plan.” According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan (Individual #6) • DSP #41 stated, “No, I have not received Training on the Occupational. ”According to the Individual Specific Training Section of the ISP, the Individual requires Occupational Therapy Plan (Individual #1) • DSP #52 stated, “No, I have not received Training on the Occupational Therapy Plan.” According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan(Individual #5) • DSP #56 stated, “No, I am not aware of the Occupational Therapy Services or Plans” According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #4) 		
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	<p>When DSP were asked if they received training on the Individual’s Physical Therapy Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #52 stated, “No, I have not received training on the Physical Therapy Plan.” According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan (Individual #5) <p>When DSP were asked if they received training on the Individual’s Crisis Plans and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #41 stated, “Medical Crisis Plans and General Crisis Plan which covers only seizures.” According to the Individual Specific Training Section of the ISP, the Individual has Allergies to tomatoes. (Individual #1) • DSP #62 stated, “No, I do not remember.” According to the Individual Specific Training Section of the ISP, the individual has a Seizure Crisis Plan. (Individual #12) <p>When DSP were asked if they received training on the Individuals’ Meal Time Plans and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #50 stated, “I’m not aware of a Mealtime Plan.” According to the Individual Specific Training Section of the ISP, the Individual requires a Mealtime Plan. (Individual #2) 		
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Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: D		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>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.</p> <p>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.</p> <p>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p>	<p>Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 2 of 19 Agency Personnel.</p> <ul style="list-style-type: none"> Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#53 & 54) 		

Tag # 1A28 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: E		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>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.</p> <p>E. Consumer and Guardian Orientation Packet: Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.</p>	<p>Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 5 of 15 individuals.</p> <ul style="list-style-type: none"> • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#2, 4, 7, 11 & 15) 		

Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: A		
<p>NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC].</p> <p>NMAC 7.26.3.13 Client Complaint Procedure Available. A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p>NMAC 7.26.4.13 Complaint Process: A. (2). The service provider's complaint or grievance procedure shall provide, at a minimum, that: (a) the client is notified of the service provider's complaint or grievance procedure</p>	<p>Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 15 individuals.</p> <ul style="list-style-type: none"> Grievance/Complaint Procedure Acknowledgement (#2) 		

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: D		
<p>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 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.</p> <p>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]</p> <p>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</p>	<p>A review of Agency Individual files indicated 1 of 15 Individuals required Human Rights Committee Approval for restrictions.</p> <p>No documentation was found regarding Human Rights Approval for the following:</p> <ul style="list-style-type: none"> • Physical Restriction (Restriction of community activities regarding behavior with children). (Individual #2) 		

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

Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval.

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.

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan.

Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006

B. 1. e. If the PRN medication is to be used in

response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).

Tag # 5I22 SE Agency Case File	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</p> <p>D. Provider Agency Requirements</p> <p>(1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.</p> <p>(2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:</p> <p>(a) Quarterly progress reports;</p> <p>(b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD;</p> <p>(c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks</p>	<p>Based on record review, the Agency failed to maintain a confidential case file for each individual for 2 of 5 individuals receiving Supported Employment Services.</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Vocational Assessment (#12 &13) 		

including the individual, as well and a review and reporting mechanism for mutual accountability; and

(d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973.

New Mexico Department of Health (DOH)
Developmental Disabilities Supports Division
(DDSD) Policy - **Policy Title: Vocational Assessment Profile Policy Eff July 16, 2008**

I. PURPOSE

The intent of the policy is to ensure that individuals are identified who could benefit from Vocational Assessment Profiles (VAPs) and are supported to access this support.

II. POLICY STATEMENT

Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures.

Tag # 5I25 SE Reimbursement	Scope and Severity Rating: B		
<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 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. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to 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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 2 of 5 individuals.</p> <p>Individual #10 December 2009</p> <ul style="list-style-type: none"> • The Agency billed 15 units of Supported Employment on 12/15/2009. No documentation found to justify billing. <p>Individual #12 December 2009</p> <ul style="list-style-type: none"> • The Agency billed 2 units of Supported Employment from 12/11/2009 through 12/12/2009. Documentation received accounted for 3.0 units. <p>January 2010</p> <ul style="list-style-type: none"> • The Agency billed .75 units of Supported Employment on 01/14/2010. No documentation found to justify billing. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 6.50 units of Supported Employment on 02/25/2010. No documentation found to justify billing. 		

E. Reimbursement

(1) Billable Unit:

(a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job.

(b) The **billable unit for Individual Supported Employment** is one hour with a maximum of four hours a month. The Individual Supported Employment hourly rate is for face-to-face time which is supported by non face-to-face activities as specified in the ISP and the performance based contract as negotiated annually with the provider agency. Individual Supported Employment is a minimum of one unit per month. If an individual needs less than one hour of face-to-face service per month the IDT Members shall consider whether Supported Employment Services need to be continued. Examples of non face-to-face services include:

- (i) Researching potential employers via telephone, Internet, or visits;
- (ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents;
- (iii) Arranging appointments for job tours, interviews, and job trials;
- (iv) Documenting job search and acquisition progress;
- (v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual's progress, needs and satisfaction; and
- (vi) Meetings with individual surrounding job development or retention not at the employer's site.

(c) Intensive Supported Employment services are intended for individuals who need one-to-one, face-to-face support for 32 or more hours per month. The billable unit is one hour.

(d) Group Supported Employment is a fifteen-

<p>minute unit.</p> <p>(e) Self-employment is a fifteen minute unit.</p> <p>(4) Billable Activities include:</p> <p>(a) Activities conducted within the scope of services;</p> <p>(b) Job development and related activities for up to ninety (90) calendar days) that result in employment of the individual for at least thirty (30) calendar days; and</p> <p>(c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDSD Regional Office.</p>			
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Tag # 5I36 CA Reimbursement	Scope and Severity Rating: B		
<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 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. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to 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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XI. COMMUNITY ACCESS</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 2 of 5 individuals.</p> <p>Individual #2 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 58 units of Community Access from 1/19/2010/ through 1/22/2010. Documentation received accounted for 56 units. <p>Individual #15 January 2010</p> <ul style="list-style-type: none"> • The Agency billed 71 units of Community Access from 1/20/2010 through 1/22/2010 Documentation received accounted for 60 units. 		

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;
- (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and
- (c) Non face-to-face hours do not exceed 10% of the monthly billable hours.

(3) Non-Billable Activities: Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:

- (a) Time and expense for training service personnel;
- (b) Supervision of agency staff;
- (c) Service documentation and billing activities; or
- (d) Time the individual spends in segregated facility-based settings activities.

Tag # 5144 AH Reimbursement	Scope and Severity Rating: B	
<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 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. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to 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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XVI. REIMBURSEMENT</p> <p>A. Billable Unit. A billable unit for Adult Habilitation</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 9 of 11 individuals.</p> <p>Individual #1 December 2009</p> <ul style="list-style-type: none"> • The Agency billed 36 units of Adult Habilitation from 12/07/2009 through 12/11/2009. Documentation received accounted for 21 units. • The Agency billed 32 units of Adult Habilitation on 12/17/2009. Documentation received accounted for 15 units. <p>January 2010</p> <ul style="list-style-type: none"> • The Agency billed 55 units of Adult Habilitation from 01/04/2010 through 01/08/2010. Documentation received accounted for 53 units • The Agency billed 56 units of Adult Habilitation from 01/11/2010 through 01/15/2010. Documentation received accounted for 54 units. • The Agency billed 38 units of Adult Habilitation from 01/21/2010 through 01/22/2010. Documentation received accounted for 28 units. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 61 units of Adult Habilitation from 02/01/2010 through 02/05/2010. Documentation received accounted for 46 units. • The Agency billed 59 units of Adult Habilitation from 02/11/2010 through 02/12/2010. Documentation received accounted for 48 units. • The Agency billed 50 units of Adult Habilitation from 02/18/2010 through 02/19/2010. Documentation received accounted for 25 units. 	

Services is in 15-minute increments hour. The rate is based on the individual's level of care.

B. Billable Activities

(1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face 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(b) Non face-to-face hours do not exceed 5% of the monthly billable hours.

(2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours

Individual #2
December 2009

- The Agency billed 112 units of Adult Habilitation from 12/14/2009 through 12/18/2009. Documentation received accounted for 66 units.

January 2010

- The Agency billed 84 units of Adult Habilitation from 01/04/2010 through 01/08/2010. Documentation received accounted for 67 units.
- The Agency billed 107 units of Adult Habilitation from 01/11/2010 through 01/15/2010. Documentation received accounted for 78 units.
- The Agency billed 83 units of Adult Habilitation from 01/25/2010 through 01/28/2010. Documentation received accounted for 79 units.

February 2010

- The Agency billed 119 units of Adult Habilitation from 02/08/2010 through 02/12/2010. Documentation received accounted for 112 units.
- The Agency billed 124 units of Adult Habilitation from 02/15/2010 through 02/19/2010. Documentation received accounted for 79 units.

Individual #3
December 2009

- The Agency billed 40 units of Adult Habilitation from 12/07/2009 through 12/09/2009. Documentation received accounted for 22 units.
- The Agency billed 39 units of Adult Habilitation from 12/21/2009 through 12/22/2009. Documentation received accounted for 37 units.
- The Agency billed 69 units of Adult Habilitation

	<p>from 12/28/2009 through 12/30/2009. Documentation received accounted for 18 units.</p> <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 70 units of Adult Habilitation from 02/10/2010 through 02/10/2010. Documentation received accounted for 56 units. • The Agency billed 40 units of Adult Habilitation from 02/16/2010 through 02/17/2010. Documentation received accounted for 29 units. <p>Individual #8</p> <p>January 2010</p> <ul style="list-style-type: none"> • The Agency billed 64 units of Adult Habilitation from 01/12/2010 through 01/15/2010. Documentation received accounted for 43 units. • The Agency billed 85 units of Adult Habilitation from 01/19/2010 through 01/22/2010. Documentation received accounted for 64 units. • The Agency billed 65 units of Adult Habilitation from 01/25/2010 through 01/28/2010. Documentation received accounted for 63 units. <p>February 2010</p> <ul style="list-style-type: none"> • The Agency billed 70 units of Adult Habilitation from 02/08/2010 through 02/12/2010. Documentation received accounted for 67 units. • The Agency billed 40 units of Adult Habilitation from 02/16/2010 through 02/19/2010. Documentation received accounted for 34 units. 		
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	<p>Individual #9 January 2010</p> <ul style="list-style-type: none"> The Agency billed 43 units of Adult Habilitation from 01/04/2010 through 01/08/2010. Documentation received accounted for 42 units. <p>Individual #10 February 2010</p> <ul style="list-style-type: none"> The Agency billed 30 units of Adult Habilitation from 02/01/2010 through 02/02/2010. Documentation received accounted for 20 units. <p>Individual #13 December 2009</p> <ul style="list-style-type: none"> The Agency billed 90 units of Adult Habilitation from 12/14/2009 through 12/18/2009. Documentation received accounted for 69 units. <p>February 2010</p> <ul style="list-style-type: none"> The Agency billed 111 units of Adult Habilitation from 02/08/2010 through 02/12/2010. Documentation received accounted for 96 units. The Agency billed 119 units of Adult Habilitation from 02/15/2010 through 02/19/2010. Documentation received accounted for 95 units. <p>Individual #14 December 2009</p> <ul style="list-style-type: none"> The Agency billed 16 units of Adult Habilitation on 12/23/2009. Documentation received accounted for 11 units. <p>January 2010</p> <ul style="list-style-type: none"> The Agency billed 25 units of Adult Habilitation on 01/11/2010. Documentation received 		
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	<p>accounted for 14 units.</p> <p>Individual #15 January 2010</p> <ul style="list-style-type: none">• The Agency billed 22 units of Adult Habilitation on 01/06/2010. Documentation received accounted for 10 units.		
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Date: June 24, 2010
To: Pamela Stafford, Executive Director
Provider: Connection, LLC
Address: 217 San Pedro NE
State/Zip: Albuquerque, New Mexico 87108
Region: Metro
Survey Date: March 22 – 26, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Stafford,

Your request for a Reconsideration of Findings was received on June 1, 2010. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A03

Determination: The IRF committee is removing the original finding in the report. However, based on documentation you provided and the findings cited in the remainder of your report this committee suggests you receive technical assistance as it appears your agency QA/QI Plan is not functioning at an acceptable level as to improve quality internal to Connections, LLC.

Regarding Tag # 1A05

Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation you supplied and documentation gathered by the survey team while on-site, this deficiency will be upheld. Documents submitted show a review of policies and procedures on 11/16/08; however the policies and/or procedures supplied to the survey team while on-site contradict this information. The policies/procedures supplied on-site clearly show dates out of compliance with standards, as noted in the original report of findings. The scope and severity rating for this tag will remain "F."

Regarding Tag # 1A29

Determination: The IRF committee is removing the original finding in the report. Based on documentation you supplied showing evidence of due diligence on your behalf, you are able demonstrate your agency was and continues to locate the guardian in question.

Regarding Tag # 1A22

Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation you supplied and documentation gathered by the survey team while on-site, this deficiency will be upheld. The Individual Specific Training (IST) section of the ISP states training for Individual # 1 is required for allergies including tomatoes and the staff “need(s) to know,” and “Health Coordinator and or nurse to inform staff.” [sic] Other deficiencies within this tag were not disputed. The scope and severity rating for this tag will remain “E.”

Regarding Tag # 1A31

Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation you supplied and documentation gathered by the survey team while on-site, this deficiency will be upheld. The deficiency in the report of findings does not cite your agency for not holding the Human Rights Committee as you are disputing; rather, you were found deficient for not having evidence of the approval of a physical restriction for Individual #2. It is advised you speak to the ancillary provider who held the Human Rights Team and maintains minutes of that meeting and collect the approval for physical restraints for your file. The scope and severity rating for this tag will remain “D.”

Regarding Tag # 5144

Determination: The IRF committee is upholding the original finding in the report. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation you supplied and documentation gathered by the survey team while on-site, as well as your rationale for disputing this deficiency it will be upheld. During the entrance meeting the “Administrative Needs List,” was signed by “Pamela Stafford,” stating your acknowledgement of specific items required to complete the survey including items number 14, “Copy of remittance records and supporting documentation for the months of December 2009, January 2010 and February 2010 for clients listed in #1.” The scope and severity rating for this tag will remain “B.”

Regarding Tag # 5125

Determination: The IRF committee is modifying the original finding in the report; other deficiencies within this tag were not disputed. Removed, were citations for Individual #12 for the months of December 2009 and February 2010. The scope and severity rating for this tag will remain “B.”

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

Thank you.
Respectfully,



Scott Good, MRC, CRC
Deputy Bureau Chief/QMB

Informal Reconsideration of Finding Committee Chair

CC: File, DHI, DDSD