



Alfredo Vigil, MD  
Secretary Designate

DEPARTMENT OF

Building a Healthy New Mexico!

Bill Richardson Governor

Katrina Hotrum  
Deputy Secretary

Duffy Rodriguez  
Deputy Secretary

Jessica Sutin  
Deputy Secretary

Karen Armitage, MD  
Chief Medical Officer

Date: February 4, 2009

To: Steve Adams, Executive Director

Provider: WNG, Community Connections  
Address: 1165 Commerce  
State/Zip: Las Cruces, New Mexico 88011

Cc: Dr. Wes Handy, Owner  
Address: 1165 Commerce  
State/Zip: Las Cruces, New Mexico 88011

Region: Southwest  
Survey Date: January 5 – 7, 2009  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Living (Supported Living & Independent Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)  
Survey Type: Focused (Safeguards for Individuals' funds and Representative Payee Responsibilities)  
Team Leader: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Crystal Lopez-Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Stephanie Martinez de Berenger, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Anthony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Barbara Czinger, MSW, LISW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau;

Report #: Q09.03.D1925.SW.001.FCD.01

Dear Mr. Adams,

The Division of Health Improvement Quality Management Bureau has completed a focused survey of the service identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. The specific focus of the survey was to determine compliance with implementation of Safeguards for Individuals' funds and Representative Payee responsibilities.

**Plan of Correction:**

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

1. Quality Management Bureau, Attention: Plan of Correction Coordinator  
5301 Central Ave. NE Suite 900 Albuquerque, NM 87108
2. Developmental Disabilities Supports Division Regional Office for region of service surveyed.

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 working days. If your plan of correction is denied, you must resubmit a revised plan ASAP for approval. All remedies must still be completed within 45 working days of the original submission.

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

**Request for Informal Reconsideration of Findings (IRF):**

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

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

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

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

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

Please call the Team Leader at 505-690-4693, 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  
Team Lead/Health Care Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: January 5, 2009

Present: **WNG, Inc. (Community Connections)**  
Steve Adams, Executive Director

**DOH/DHI/QMB**

Deb Russell, BS, Team Lead/Healthcare Surveyor  
Crystal Lopez-Beck, BA, Healthcare Surveyor  
Stephanie Martinez de Berenger, MPA, Healthcare Surveyor  
Anthony Fragua, BFA, Healthcare Surveyor  
Barbara Czinger, MSW, LISW, Healthcare Surveyor

Exit Conference Date: January 7, 2009

Present: **WNG, Inc. (Community Connections)**  
Steve Adams, Executive Director  
Christina Villegas, Vocational Coordinator  
Susan Valencia, Service Coordinator  
Yolanda Costales, Program Manager  
Barbara Rupe, Corporate

**DOH/DHI/QMB**

Deb Russell, BS, Team Lead/Healthcare Surveyor  
Crystal Lopez-Beck, BA, Healthcare Surveyor  
Stephanie Martinez de Berenger, MPA, Healthcare Surveyor  
Anthony Fragua, BFA, Healthcare Surveyor  
Barbara Czinger, MSW, LISW, Healthcare Surveyor  
Valerie Valdez, MS, Program Manager

**DDSD - Southwest Regional Office**

Scott Doan, Program Manager

Administrative Locations Visited	Number:	1
Total Sample Size	Number:	9
Persons Served Interviewed	Number:	1
Records Reviewed (Persons Served)	Number:	9
Administrative Files Reviewed		<ul style="list-style-type: none"><li>• Policies and Procedures</li><li>• Individual Financial Records (i.e. check registers, bank statements, receipts, etc.)</li></ul>

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

- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, 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.
	Med. Impact	No Actual Harm Potential for more than minimal harm	D.	E.	F. (3 or more)
			D. (2 or less)		F. (no conditions of participation)
	Low Impact	No Actual Harm Minimal potential for harm.	A.	B.	C.

Scope and Severity Definitions:

Key to Scope scale:

Isolated:

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

Pattern:

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

Widespread:

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

Key to Severity scale:

Low Impact Severity: (Blue)

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

Medium Impact Severity: (Tan)

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

High Impact Severity: (Green or Yellow)

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

High Impact Severity: (Yellow)

“J, K, and L” Level findings:

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

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

### **Introduction:**

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

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

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

### **The following limitations apply to the IRF process:**

- The request for an IRF and all supporting evidence must be received in 10 days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed by the survey team.
- Providers must continue to complete their plan of correction during the IRF process
- Providers may not request an IRF to challenge the Scope and Severity of a finding.
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition
- Providers may not request an IRF to challenge the QMB Quality Approval Rating and the length of their DDS 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 DDS 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:** WNG, Inc. (Community Connections) - Southwest Region  
**Program:** Developmental Disabilities Waiver  
**Service Surveyed:** Community Living (Supported Living & Independent Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)  
**Survey Type:** Focused (Safeguards for Individuals' funds and Representative Payee Responsibilities)  
**Date of Survey:** January 5 -7, 2009

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<b>Tag # 1A07 SSI Payments</b>	<b>Scope and Severity Rating: E</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> 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><b>C. Provider Agency Financial Records and Accounting:</b> Each individual served will be presumed able to manage his or her own funds unless the ISP documents justified limitations or supports for self-management, and where appropriate, reflects a plan to increase this skill. All Provider Agencies shall maintain and enforce written policies and procedures regarding the use of the individual's SSI payments or other personal funds, including accounting for all spending by the Provider Agency, and outlining protocols for fulfilling the responsibilities as representative payee if the agency is so designated for an individual.</p> <p><b>Code of Federal Regulations:</b></p> <p><b>§416.635 What are the responsibilities of your representative payee...</b></p> <p>A representative payee has a responsibility to:</p>	<p>Based on record review, the Agency failed to maintain and enforce written policies and procedures regarding the use of individuals' SSI payments or other personal funds, including accounting for all spending by the Provider Agency, and outlining protocols for fulfilling the responsibilities as representative payee if the agency is so designated for an individual for 3 of 9 individuals.</p> <p>As noted in The Code of Federal Regulations (CFR 20) states, "416.640... 3) Representative payees must keep records and receipts of all deposits to and expenditures from dedicated accounts, and must submit these records to us upon our request, as explained in <u>§416.635</u> and <u>§416.665</u>."</p> <p>During the on-site visit (Jan. 5 - 7, 2009) review of individual financial records found no evidence of receipts to account for expenditures:</p> <p><b>Individual #3</b></p> <ul style="list-style-type: none"> <li>• Check #1464 written 2/7/08 in the amount of \$100.00</li> <li>• Check #1465 written 2/19/08 in the amount of \$100.00</li> <li>• Check #1467 written 3/3/08 in the amount of \$250.00</li> <li>• Check #1470 written 3/21/08 in the amount of \$250.00</li> <li>• Check #1476 written 4/10/08 in the</li> </ul>		

(a) Use the benefits received on your behalf only for your use and benefit in a manner and for the purposes he or she determines under the guidelines in this subpart, to be in your best interests;

(b) Keep any benefits received on your behalf separate from his or her own funds and show your ownership of these benefits unless he or she is your spouse or natural or adoptive parent or stepparent and lives in the same household with you or is a State or local government agency for whom we have granted an exception to this requirement;

(c) Treat any interest earned on the benefits as your property;

(d) Notify us of any event or change in your circumstances that will affect the amount of benefits you receive, your right to receive benefits, or how you receive them;

(e) Submit to us, upon our request, a written report accounting for the benefits received on your behalf, and make all supporting records available for review if requested by us;

(f) Notify us of any change in his or her circumstances that would affect performance of his/her payee responsibilities; and

**§416.640 Use of benefit payments.**

(a) *Current maintenance.* We will consider that payments we certify to a representative payee have been used for the use and benefit of the beneficiary if they are used for the beneficiary's current maintenance. Current maintenance includes costs incurred in obtaining food, shelter, clothing, medical care and personal comfort items.

amount of \$100.00

- Check #1477 written 4/25/08 in the amount of \$150.00
- Check #1478 written 5/1/08 in the amount of \$300.00
- Check #1483 written 5/12/08 in the amount of \$150.00
- Check #1484 written 5/23/08 in the amount of \$50.00
- Check #1485 written 6/2/08 in the amount of \$250.00
- Check #1487 written 6/20/08 in the amount of \$200.00
- Check #1489 written 6/16/08 in the amount of \$100.00
- Check #1492 written 7/2/08 in the amount of \$125.00
- Check #1494 written 7/18/08 in the amount of \$60.00
- Check #1497 written 7/12/08 in the amount of \$20.00
- Check #1498 written 7/18/08 in the amount of \$60.00
- Check #1499 written 7/25/08 in the amount of \$65.00
- Check #1502 written 8/1/08 in the amount of \$60.00
- Check #1506 written 8/6/08 in the amount of \$100.00
- Check #1507 written 8/8/08 in the amount of \$60.00

**Individual #7**

- Check #1727 written 4/14/08 in the amount of \$325.00

**Individual #8**

- Check #1814 written 6/10/8 in the amount of \$100.00
- Check #1828 written 7/7/08 in the amount of \$150.00
- Check #1838 written 7/28/08 in the amount of \$166.00
- Check #1857 written 9/3/08 in the amount of \$130.00

**§416.665 How does your representative payee account for the use of benefits...**

Your representative payee must account for the use of your benefits. We require written reports from your representative payee at least once a year (except for certain State institutions that participate in a separate onsite review program). We may verify how your representative payee used your benefits. Your representative payee should keep records of how benefits were used in order to make accounting reports and must make those records available upon our request.

Per Agency policy, "Management of Client Funds" dated, 7/5/2006, it stated, "Receipts will be kept on file of each expense with reference to the check number."

Tag # 1A07 SSI Payments	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> 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><b>C. Provider Agency Financial Records and Accounting:</b> Each individual served will be presumed able to manage his or her own funds unless the ISP documents justified limitations or supports for self-management, and where appropriate, reflects a plan to increase this skill. All Provider Agencies shall maintain and enforce written policies and procedures regarding the use of the individual's SSI payments or other personal funds, including accounting for all spending by the Provider Agency, and outlining protocols for fulfilling the responsibilities as representative payee if the agency is so designated for an individual.</p>	<p>Based on record review, Agency Financial Records for January 2008 - December 2008, the Agency failed to maintain and enforce written policies and procedures regarding the use of individuals' SSI payments or other personal funds for 9 of 9 individuals.</p> <p>Per the Agency Policy: "Management of Individual Funds Effective October 22, 2008," it stated, " Program Managers will review the completed reconciliation packet followed by the Executive Director, who will review the reconciliation packet within the week the account is reconciled." Additionally the Agency's, "Management of Individual Funds Addendum Effective December 8, 2008," stated, "When there is a vacancy in the position of Billing Clerk, the following adjustments to the procedure will be implemented: ...b. Two staff persons will be designated to conduct the over site duties that the executive director usually performs."</p> <p>Review of the Agency's Financial Records contained no evidence of oversight:</p> <ul style="list-style-type: none"> <li>• Financial Records for November 2008 showed no two staff person oversight as per Agency policy. (#1 – 9)</li> </ul>		