SUSANA MARTINEZ, GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

RETTA WARD, CABINET SECRETARY

Date: January 30, 2015

To: Dave Murley, Executive Director
Provider: AAA Participant Direction
Address: 4300 Silver SE, Suite B
State/Zip: Albuquerque, New Mexico 87108

E-mail Address: dmaaapd@gmail.com

Region: Statewide
Survey Date: December 12-17, 2014

Program Surveyed: Mi Via Waiver
Service Surveyed: Mi Via Consultation Services
Survey Type: Initial

Team Leader: Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Nicole Brown, MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Corrina Strain, RN, BSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Valerie Valdez, M.S, Bureau Chief, Division of Health Improvement/Quality Management Bureau;

Dear Mr. Murley;

The Division of Health Improvement/Quality Management Bureau Mi Via Survey Unit has completed a compliance 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 Mi Via Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Plan of Correction:
The attached Report of Findings identifies the deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

Submission of your Plan of Correction:
Please submit your agency's Plan of Correction in the space on the right-hand column of the Report of Findings. *(See attachment "A" for additional guidance in completing the Plan of Correction)*.

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

- **Quality Management Bureau**
  Attention: Plan of Correction Coordinator
  5301 Central Ave. NE Suite 400 Albuquerque, NM 87108

- **Developmental Disabilities Supports Division**
  Attention: Mi Via Program Manager
  5301 Central Ave. NE Suite 200 Albuquerque, NM 87108

Upon notification that your Plan of Correction has been approved, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may 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 finding of deficient practice, you have 10 business 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

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the QMB Plan of Correction Coordinator at 505-231-7436 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Erica Nilsen, BA

Erica Nilsen, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	December 15, 2014
Present:	**AAA Participant Direction** Dave Murley, President Rebecca Shuman, Operations Manager/Consultant Pam Crumpler, Consultant **DOH/DHI/QMB** Erica Nilsen, BA, Team Lead/Healthcare Surveyor Nicole Brown, MBA, Healthcare Surveyor Corrina Strain, RN, BSN, Healthcare Surveyor Valerie Valdez, MS, Bureau Chief **DDSD – Mi Via Program** Regina Lewis, Mi Via Program Coordinator
Exit Conference Date:	December 17, 2014
Present:	**AAA Participant Direction** Dave Murley, President Rebecca Shuman, Operations Manager/Consultant Pam Crumpler, Consultant Tess Adkins, Consultant Paul Kline, Consultant **DOH/DHI/QMB** Erica Nilsen, BA, Team Lead/Healthcare Surveyor Nicole Brown, MBA, Healthcare Surveyor Corrina Strain, RN, BSN, Healthcare Surveyor Valerie Valdez, MS, Bureau Chief **DDSD – Mi Via Program** Regina Lewis, Mi Via Program Coordinator

Administrative Locations Visited	Number:	1 (4300 Silver SE, Suite B, Albuquerque, NM 87108)
Total Sample Size	Number:	40
Participant Records Reviewed	Number:	40
Consultant Staff Records Reviewed	Number:	12

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Participant Program Case Files
- Personnel Files
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Quality Assurance / Improvement Plan

CC: Distribution List:

DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division

Attachment A

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

Introduction:
After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued deficiencies and non-compliance.

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings (Providers who fail to complete a POC within the 45 business days allowed will be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 505-231-7436 or email at Anthony.Fragua@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

Instructions for Completing Agency POC:

Required Content
Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

The Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

- How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
- How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
- What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
- Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan

must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
- The POC must be signed and dated by the agency director or other authorized official.

Note: **Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps should be taken to ensure the deficiency is corrected and will not recur.

Completion Dates

The plan of correction must include a **completion date** for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.

Some deficiencies may require a staged plan to accomplish total correction.

Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Initial Submission of the Plan of Correction Requirements

The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.

For questions about the POC process, call the POC Coordinator, Anthony Fragua at 505-231-7436 for assistance.

For Technical Assistance (TA) in developing or implementing your POC, contact your Mi Via Liaison at the Regional DDSD Office.

Submit your POC to Anthony Fragua, POC Coordinator in any of the following ways:

Electronically at Anthony.Fragua@state.nm.us *(preferred method)*
Fax to 505-222-8661, or

Mail to POC Coordinator, 5301 Central Avenue NE, Suite 400, Albuquerque, NM 87108

Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.

QMB will notify you when your POC has been "approved" or "denied."

During this time, whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.

If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45-business day limit is in effect.

If your POC is denied a second time your agency may be referred to the Internal Review Committee.

You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.

Please note that all POC correspondence will be sent electronically unless otherwise requested.

Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

- Your internal documents are due within a *maximum* of 45 business days of receipt of your Report of Findings.

- It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI), the preferred method is that you submit your documents electronically.
- All submitted documents ***must be annotated***; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
- Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
- In lieu of some documents, you may submit copies of file audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
- When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC. for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
    - Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
    - Copies of "void and adjust" forms submitted to Xerox State Healthcare, LLC. to correct all unjustified units identified and submitted for payment during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Deputy Chief at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

Attachment C

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

Introduction:
Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated "Document Request," or "Administrative Needs," etc. forms. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

Instructions:

- The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
- 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
- The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
- The IRF request must include all supporting documentation or evidence.

5. If you have questions about the IRF process, email the IRF Chairperson, Crystal Lopez-Beck at crystal.lopez-beck@state.nm.us for assistance.

The following limitations apply to the IRF process:

The written request for an IRF and all supporting evidence must be received within 10 business 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 or requested 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 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 DHI/QMB determination of compliance or the length of their DDSD provider contract.

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

The IRF Committee will review the request, 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 removed or modified, it will be noted and removed or modified from the Report of Findings. 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.

The Citations in the following Report of Findings are based on the Mi Via Self-Directed Waiver Program Service Standards, effective 2/2012, the New Mexico Administrative Code (NMAC) 8.314.6 among other noted standards and regulations.

Agency: **AAA Participant Direct - Statewide**
Program: Mi Via Waiver
Service: Consultant Services
Monitoring Type: Initial Survey
Survey Date: **December 12-17, 2014**

Tag	Standard of Care Mi Via Self-Directed Waiver Program Service Standards, effective 2/2012, unless otherwise noted	Deficiencies	Agency Plan of Correction, On-going QA/QI, Responsible Party and Date Due
4.5	**Pre-Eligibility and Enrollment Services**		
	Consultant Pre-Eligibility/Enrollment Services are intended to provide information, support, guidance, and/or assistance to individuals during the Medicaid eligibility process, which includes both financial and medical components. During this phase, consultants will a. Meet with the participant for an initial orientation and enrollment meeting; b. Inform, support, and assist as necessary with the requirements for establishing the LOC; c. Assist with financial eligibility application and paperwork as needed; and d. Verify that the county ISD office of the HSD has completed a determination that the individual meets financial and medical eligibility to participate in the Mi Via Waiver program.	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 6 of 40 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: • Evidence of ISD Approval Letter or Screen Shot indicating financial eligibility. (#6, 22) • Evidence of the "Choosing Mi Via: Understanding Participant Responsibilities" consent form. (#2, 14, 23, 35) • Evidence the Consultant made contact at least monthly during the eligibility phase. No evidence of monthly contact found for	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

	Appendix A: **Service Descriptions in Detail 2009 Waiver Renewal** **CONSULTANT/SUPPORT GUIDE** **PRE-ELIGIBILITY/ENROLLMENT SERVICES** **II. Scope of Service** Consultant pre-eligibility/enrollment services are delivered in accordance with the individual's identified needs. Based upon those needs, the consultant provider selected by the individual shall: A. Assign a consultant and contact the individual within five (5) working days after receiving the PFOC to schedule an initial orientation and enrollment meeting; B. The actual enrollment meeting should be conducted within 30 days. Enrollment activities include but are not limited to: 1. General program overview including key agencies and contact information; 2. Discuss medical and financial eligibility requirements and offer assistance in completing these requirements as needed; 3. Provide information on Mi Via participant roles and responsibilities; 4. Discussion of Employer of Record (EOR) including discussion and possible identification of an EOR and completion of the EOR information form;	04/2014, 05/2014 and 06/2014. (#22)	

	5. Review the processes for hiring employees and contractors and required paperwork; 6. Review the process and paperwork for hiring Legally Responsible Individuals (LRI) as employees; 7. Discuss the background check and other credentialing requirements for employees and contractors; 8. Referral for accessing training for the GCES*on-line* system; and to obtain information on the Financial Management Agency (FMA); and 9. Provide information on the Service and Support Plan (SSP) including covered goods and services, planning tools and community resources available. Mi Via Consultant Guide (4/12) pg. 16 Mi Via Consultant Guide (4/12) pg. 31 Mi Via Consultant Guide (4/12) pg. 33		

4.6	On-going Consultant Functions		
	After eligibility has been verified, consultants assist the participant with virtually every aspect of the Mi Via program. The extent of assistance is based upon individual participant needs, and may include (but is not limited to) help and guidance related to 1. Understanding participant and EOR roles and responsibilities; 2. Identifying resources outside the Mi Via program, including natural and informal supports, that may assist in meeting the participant's needs; 3. Understanding the array of Mi Via covered supports, services, and goods; 4. Developing a thoughtful and comprehensive SSP/budget that includes services and supports, covered by the Mi Via program, to address the needs of the participant; 5. Developing, documenting and submitting an appropriate SSP/budget request to implement the SSP/budget; 6. Employer-related activities such as identifying an EOR, finding and hiring employees and contractors, and completing all documentation required by the FMA; 7. Identifying and resolving issues related to the implementation of the SSP/budget; 8. Assist the participant with quality assurance activities to ensure implementation of the participant's SSP/budget, and utilization of the authorized budget; and 9. Recognizing and reporting critical incidents, including abuse, neglect, exploitation, emergency services, law enforcement involvement, and environmental hazards. Consultants will contact the participant at least once a month for a 'check-in' and meet face-to-face with the participant at least once every three (3) months to	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 13 of 40 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: • Client Individual Assessment (CIA) (#20, 21, 23, 27, 31, 35) • Vineland Assessment (#20, 21, 23, 24, 27, 31, 35) • Legally Responsible Individual (LRI) Acknowledgement Form (#31) • Emergency Backup Plan Acknowledgement Form (#9, 14, 20, 23, 35, 40) • Guardianship Documentation (#14, 23, 27) **Monthly Contacts** • Individual #25- none found for 9/2014 • Individual #27- none found for 11/2014 **Quarterly Visits** • Individual #13 –none found for 12/2013-5/2014 • Individual #25 –none found for 6/2014-9/2014 • Individual #27 –none found for 10/2013-1/2014 • Individual #37 –none found for 11/2014	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

	• Review spending patterns; • Review and document progress of SSP/budget implementation; • Document the usage and effectiveness of the 24 hour Emergency Backup Plan; • Document the purchase of goods; • Review and document the progress of the SSP/budget implementation; and • Document the usage and effectiveness of the 24 hour emergency backup plan. • revisions. NMAC 8.314.6.12, Record Keeping and Documentation Responsibilities NMAC 8.302.1.17 NMAC - Record Keeping and Documentation Requirements NMAC 8.302.1 NMAC - General Provider Policies New Mexico Human Services Register Vol. 34, No 10 March 14, 2011 Pg. 8 Mi Via Consultant Guide (4/12) pg. 31 Mi Via Consultant Guide (4/12) pg. 63 – Incident Management Process for Aged & Disabled and Brain Injury NMAC 7.1.14, Abuse, Neglect, Exploitation, Suspicious Injury and Unexpected Death Reporting, Intake, Processing and Training Requirements for Community Based Service Providers Mi Via Consultant Guide (4/12) – Appendix L, Pg. 107 – Documentation of Services Policy State of NM, DOH, DDSD Terms of the Provider Agreement		

5.2	Eligibility Reevaluation Process		
	Annual Medical Eligibility Process Medical eligibility redetermination occurs every 12 months, and follows essentially the same process as the initial LOC evaluation. The participant will receive a letter from the TPA 90 days prior to the expiration of his/her LOC, informing them of how to proceed with the process and providing the appropriate forms and instructions. The TPA uses a tracking system to ensure that eligibility re-evaluations LOC are completed on an annual basis and according to the timeliness requirements.	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 5 of 40 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: • Approval Letter from the Third Party Assessor (TPA) indicating medical eligibility (#38) • Long Term Care Assessment Abstract (LTCAA) (#6, 20, 27, 31, 38)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

6.3	Participant's Budget-Related Authority		
	Participant's Budget-Related Authority There are three (3) elements to the authority participants have related to their budgets budget making authority, employer authority, and budget spending authority. **Participant Budget-Spending Authority** Participants have authority to expend waiver funds for services through an AAB that shall be expended on a monthly basis over the course of the budget year and according to the participant's approved SSP/budget. **Employer Authority** The participant (or the participant's representative) is the common law employer of service providers. The FMA serves as the participant's agent in conducting payroll and other employer-related responsibilities that are required by Federal and State law. **Participant Decision-Making Authority** Participants shall have authority to do the following • Complete the employer paperwork to be submitted to the FMA. Participants who do not plan to hire employees are not required to complete employer paperwork, but the program advises that all participants take this step. Participants frequently change their plans about hiring employees during the course of their SSP/budget year, and completing this process often takes several weeks. Getting the employer paperwork out of the way at the beginning of the year may make future changes easier; • Determine the amount paid for services within the State's limits; • Schedule the provision of services; • Specify service provider qualifications of the participant's choice, consistent with the qualifications specified in the Mi Via regulations and the service standards in ; • Specify how services are provided, consistent with the	Based on record review the Agency did not maintain a complete and confidential case file at the administrative office for 2 of 40 participants. Review of the Agency's participant case files revealed the following items were not found, incomplete, and/or not current: • Proof that recipient received a copy of their approved Service and Support Plan (SSP) and budget was not found. (#13, 37)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

	Mi Via regulations and the service standards in ; • Identify service providers and vendors and refer them to the FMA for enrollment; • Arrange to have service providers paid for their services by ensuring that all proposed employees and service providers complete all FMA required paperwork, including a criminal background check when necessary. Although services may be provided before the FMA enrollment process is completed, payment for services cannot be made until paperwork is complete and submitted to the FMA; • Review, approve and submit timesheets to the FMA within established timeframes. Timesheets may be submitted to the TPA by fax or through GCES*on-line*. Failure to submit timesheets within the required timeframes could result in employees not being paid; • Approve payment, according to the AAB, for waiver services and goods identified in the approved SSP. The participant must submit an invoice or receipt from a vendor for any item he/she has planned and budgeted to purchase. • Participants cannot be reimbursed directly for any services and goods or supports; • The participant shall follow the AAB; • The participant shall work with the FMA to have all employees, providers and vendors approved and enrolled prior to delivery or provision of any service or good; and • The participant shall be accountable for the use of Mi Via funds. New Mexico Human Services Register Vol. 34, No 10 March 14, 2011		

14.A	Qualifications/Requirements		
	Service Descriptions in Detail 2009 Waiver Renewal **Appendix A:** **VI. Qualifications** A. Consultant providers shall ensure that all individuals providing consultant services meet the criteria specified in this section: Consultant providers shall: Be at least 18 years of age; Possess a minimum of a Bachelor's degree in social work, psychology, human services, counseling, nursing, special education or closely related field; Have one year of supervised experience working with seniors and/or people living with disabilities; Complete all required Mi Via orientation and training courses; and Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC. OR Consultant providers shall: Be at least 18 years of age; Have a minimum of six (6) years of direct experience related to the delivery of social services to seniors and/or people living with disabilities ; Be employed by an enrolled Mi Via Consultant Provider agency; Complete all required Mi Via orientation and training courses; and Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-	Based on record review the Agency did not maintain a complete and confidential case file at the administrative office for 2 of 40 participants. **The following Agency personnel records contained no evidence of the Consultant meeting the following required qualifications:** • Possess a minimum of a Bachelor's degree or 6 years of related experience. (#302, 306, 307) **The following Agency personnel records contained no evidence of the Mi Via Training Course being completed:** • #303 – Date of hire 1/25/2014.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

	2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC. **8.314.6.11 QUALIFICATIONS FOR ELIGIBLE INDIVIDUAL EMPLOYEES, INDEPENDENT PROVIDERS, PROVIDER AGENCIES, AND VENDORS** C. **Service specific qualifications for consultant services providers** In addition to general requirements, a consultant provider shall ensure that all individuals hired or contracted consultant services meet the criteria specified in this section in addition to as well to perform all applicable rules and service standards. Consultant providers shall possess a minimum of a bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field, and have one year of supervised experience working with the elderly or people living with disabilities; or have a minimum of six years of direct experience related to the delivery of social services to the elderly or people living with disabilities, and be employed by an enrolled mi via consultant provider agency; and complete all required mi via orientation and training courses. Consultant providers may also use non-professional staff to carry out support guide functions. Support guides provide more intensive supports, as detailed in the service section of these rules. Support guides help the eligible recipient more effectively self-direct services when there is an identified need for this type of assistance. Consultant providers shall ensure that non-professional support staff are supervised by a qualified consultant as specified in this regulation; have experience working with seniors or		

	people living with disabilities; demonstrate the capacity to meet the eligible recipient's assessed needs related to the implementation of the SSP; possess knowledge of local resources, community events, formal and informal community organizations and networks; are able to accommodate a varied, flexible and on-call type of work schedule in order to meet the needs of the eligible recipient; and complete training on self-direction and incident reporting.		

14.A.1	Administrative Requirements		
	Service Descriptions in Detail 2009 Waiver Renewal **Appendix A:** V. Administrative Requirements The consultant provider shall comply with all applicable federal, state and waiver regulations, all policies and procedures governing consultant services, all terms of their provider agreement and shall meet all of the following requirements, as applicable: Have a current business license issued by the state, county or city government as required; Maintain financial solvency; Ensure all employees providing consultant services under this standard attend all state-required orientation and trainings and demonstrate knowledge of and competence with the Mi Via policies and procedures, philosophy, including self-direction, financial management processes and responsibilities, needs assessments, person-centered planning and service plan development, and adhere to all other training requirements as specified by the state; Ensure that all employees are trained and competent in the use of the fiscal management and GCESonline system; Ensure all employees providing services under this scope of service and all other staff paid with Mi Via funds, are trained on	Based on record review, the Agency did not meet the Administrative Requirements as required by standard. • Evidence that the Consultant Agency conducted an annual participant satisfaction survey was not found for 2013-2014.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

	how to identify and where to report critical incidents abuse, neglect and exploitation; and Ensure compliance with the Caregivers Criminal History Screening Requirements (7.1.9 NMAC) for all employees. The consultant provider shall develop a quality management plan to ensure compliance with regulatory and program requirements and to identify opportunities for continuous quality improvement. The consultant provider shall conduct an annual participant satisfaction survey. A copy of a report summarizing the results of this survey must be submitted to the New Mexico Department of Health, Developmental Disabilities Supports Division upon provider renewal or as requested by the state. The consultant provider shall ensure that participants have access to the consultant provider. This requirement includes, but is not limited to the following: The consultant provider must maintain a presence in each region for which they are providing services; The consultant provider must maintain a consistent way (for example, phone, pager, email, and fax) for the participant to contact the consultant provider during typical business hours which are 8:00 a.m. to 5:00 p.m. Monday through Friday; The consultant provider must maintain a consistent way (for example phone, pager, email, and fax) for the participant to contact the consultant provider during non-business hours: prior to 8:00 a.m. and		

	after 5:00 p.m. MST on weekdays and on weekends and for emergency purposes; The consultant provider must provide a location to conduct confidential meetings with participants when it is not possible to do so in the participant's home. This location must be convenient for the participant and compliant with the Americans with Disabilities Act (ADA); The consultant provider must maintain an operational fax machine at all times; and The consultant provider must maintain an operational email address, internet access, and the necessary technology to access Mi Via related systems. The consultant provider shall maintain a current local/state community resource manual. The consultant provider shall adhere to Medicaid General Provider policies 8.302.1. The consultant provider shall maintain HIPAA compliant primary records for each participant including, but not limited to: Current and historical SSPs and budgets; Contact log that documents all communication with the participant; Completed/signed quarterly visit form(s); TPA documentation of approvals/denials, including budgets and requests for additional funding; TPA correspondence; (requests for additional information; requests for additional funding, etc); Assessor's individual specific health and safety recommendations; Notifications of medical and financial eligibility; Approved Long Term Care Assessment		

	Abstract with level of care determination and Individual Budgetary Allotment from the TPA; Budget utilization reports from the FMA; Environmental modification approvals/denials; Legally Responsible Individual (LRI) approvals/denials; Documentation of participant and employee incident management training; Copy of legal guardianship or representative papers and other pertinent legal designations; and Copy of the approval form for the authorized representative. The consultant provider shall ensure the development and implementation of a written grievance procedure in compliance with 8.349.2.11 NMAC. The consultant provider shall meet all of the qualifications set forth in 8.314.6.11 NMAC.		

1A25	Caregiver and Hospital Caregiver Employment Requirements		
	7.1.9.6 OBJECTIVE The objective of this part of Chapter 1, General Provisions, under Title 7, Health, is to establish the requirements for complying with the Caregivers Criminal History Screening Act. Generally included within these rules are the requirements and procedures for submission of applicant, caregiver and hospital caregiver fingerprints, payment of fees and administrative reconsideration for a disqualifying conviction. These rules are intended to have all covered care providers meeting the requirements of the act. **7.1.9.9** **A. Prohibition on Employment** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.	Based on record review, the Agency did not maintain documentation in the employee's personnel records indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 5 of 12 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** • #300 – Date of hire 2/13/2014 • #302 – Date of hire 11/1/2011 • #305 – Date of hire 7/7/2014 • #307 – Date of hire 12/1/2013 • #311 – Date of hire 1/25/2014	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

1A26	Employee Abuse Registry / Consolidated Online Registry		
	7.1.12.6 OBJECTIVE The objective of this rule is to implement the Employee Abuse Registry Act. The rule is intended to provide guidance as to the rights and responsibilities under the Employee Abuse Registry Act of providers, employees of providers, the department of health and the adult protective services division of the department of aging and long term services, and the public including recipients of care and services from providers.	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 11 of 12 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** • #300 – Date of hire 1/25/2014. Completed on 2/13/2014. • #301 – Date of hire 11/1/2011. Completed on 12/17/2014. • #302 – Date of hire 11/1/2011. Completed on 12/16/2014. • #303 – Date of hire 1/25/2014. Completed on 12/17/2014. • #304 – Date of hire 1/25/2014. Completed on 12/17/2014. • #305 – Date of hire 7/7/2014. Completed on 12/17/2014. • #306 – Date of hire 4/1/2011. Completed on 12/13/2014. • #307 – Date of hire 12/1/2013. Completed on 12/17/2014. • #308 – Date of hire 4/1/2011. Completed on 12/13/2014. • #309 – Date of hire 4/1/2011. Completed	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

		on 12/13/2014. • #311 – Date of hire 1/25/2014. Completed on 12/17/2014.	

1A28.1	Incident Mgt. System - Personnel Training		
	NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer. **C. Incident management system training curriculum requirements:** **(1)** The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not	Based on record review and interview, the Agency did not ensure Incident Management Training for 1 of 12 Agency Personnel. • Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (#304)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

	limited to: **(a)** an overview of the potential risk of abuse, neglect, or exploitation; **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths; **(d)** specific instructions on how to respond to abuse, neglect, or exploitation; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. **(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule. **(3)** All new employees and volunteers shall receive training prior to providing services to consumers. **D. Training documentation:** All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule.		

Date: June 4, 2015

To: Dave Murley, Executive Director
Provider: AAA Participant Direction
Address: 4300 Silver SE, Suite B
State/Zip: Albuquerque, New Mexico 87108

E-mail Address: dmaaapd@gmail.com

Region: Statewide
Survey Date: December 12-17, 2014

Program Surveyed: Mi Via Waiver
Service Surveyed: Mi Via Consultation Services
Survey Type: Initial

Dear Mr. Murley;

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete.

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

Consistent use these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Tony Fragua

Tony Fragua
Health Program Manager/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.15.2.MVW.68289758.1/2/3/4/5.INT.09.15.155