



Alfredo Vigil, MD
Secretary

DEPARTMENT OF

Building a Healthy New Mexico!

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Deputy Secretary

Karen Armitage, MD
Chief Medical Officer

Date: June 29, 2009

To: Donald Sweeney, Executive Director
Provider: Above & Beyond, Inc.
Address: 1116 Pennsylvania NE
State/Zip: Albuquerque, New Mexico 87110

CC: Marcus Cameron, Managing Director/Board Chair
Address: 1116 Pennsylvania NE
State/Zip: Albuquerque, New Mexico 87110

E-mail Address: cameroma3@msn.com

Region: Metro
Survey Date: May 18 – 21, 2009
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living) & Community Inclusion (Adult Habilitation & Community Access)

Survey Type: Routine
Team Leader: Stephanie R, Martinez de Berenger, MPA, GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Barbara Czinger, MSW, LISW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Florie Alire, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Crystal Lopez – Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Sweeney,

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 granting your agency a “STANDARD” certification 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 900 Albuquerque, NM 87108
2. Developmental Disabilities Supports Division Regional Office for region of service surveyed.
“Assuring safety and quality of care in New Mexico’s health facilities and community-based programs.”

David Rodriguez, Division Director • Division of Health Improvement

Division of Health Improvement • Quality Management Bureau • 5301 Central Ave NE • Suite 900 • Albuquerque, New Mexico 87108
(505) 222-8623 • FAX: (505) 841-5815

DHI Quality Review Survey Report – Above & Beyond, Inc – Metro Region – May 18 – 21, 2009

Report #: Q09.04.85432857.METRO.001.RTN.01

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 505-222-8641, 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
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: May 18, 2009

Present:

Above & Beyond, Inc.

Donald Sweeney, Executive Director
Marcus Cameron, Managing Director
Anita J. Vallejos, Office Manager

DOH/DHI/QMB

Stephanie R. Martinez de Berenger, MPA, GCDF
Team Lead/Healthcare Surveyor
Barbara Czinger, MSW, LISW, Healthcare Surveyor
Florie Alire, RN, Healthcare Surveyor

Exit Conference Date: May 21, 2009

Present:

Above & Beyond, Inc.

Marcus Cameron, Managing Director
Donald Sweeney, Executive Director
Nicole Chavez, Program Director
Anita J. Vallejos, Office Manager
Sara Elliott, Director Quality Improvement
Joanne Passeri, Day Service Director

DOH/DHI/QMB

Stephanie R. Martinez de Berenger, MPA, GCDF
Team Lead/Healthcare Surveyor
Florie Alire, RN, Healthcare Surveyor

DDSD - Metro Regional Office

Selma Dodson, Social & Community Services Coordinator

Homes Visited Number: 5

Administrative Locations Visited Number: 1

Total Sample Size Number: 8
0 - Jackson Class Members
8 - Non-Jackson Class Members
6 - Supported Living
4 - Adult Habilitation
2 - Community Access

Persons Served Interviewed Number: 7

Persons Served Observed Number: 1 (Individual was not available during the on-site week of May 18 – 21, 2009)

Records Reviewed (Persons Served) Number: 8

Administrative Files Reviewed

- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry

- Human Rights Notes and/or Meeting Minutes
- Nursing personnel files
- Evacuation Drills
- Quality Improvement/Quality Assurance Plan

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

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8624.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency (“Responsible Party”), and by WHEN (“Date Due”).
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency’s Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-841-5815), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been “Approved” or “Denied”.
- Whether your POC is “Approved” or “Denied”, you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is “Denied” it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- The following Deficiencies must be corrected within the deadlines below (after receipt of your Survey Report):
 - CCHS and EAR: 10 working days
 - Medication errors: 10 working days
 - IMS system/training: 20 working days
 - ISP related documentation: 30 working days
 - DDSD Training 45 working days
- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8624 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

QMB Scope and Severity Matrix of survey results

Each deficiency in your Report of Findings is scored on a Scope and Severity Scale. The culmination of each deficiency’s Scope and Severity is used to determine degree of compliance to standards and regulations and level of QMB Certification.

			SCOPE		
			Isolated 01% - 15%	Pattern 16% - 79%	Widespread 80% - 100%
SEVERITY	High Impact	Immediate Jeopardy to individual health and or safety	J.	K.	L.
		Actual harm	G.	H.	I.
	Medium Impact	No Actual Harm Potential for more than minimal harm	D.	E.	F. (3 or more)
			D. (2 or less)		F. (no conditions of participation)
	Low Impact	No Actual Harm Minimal potential for harm.	A.	B.	C.

Scope and Severity Definitions:

Key to Scope scale:

Isolated:

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

Pattern:

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

Widespread:

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

Key to Severity scale:

Low Impact Severity: (Blue)

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

Medium Impact Severity: (Tan)

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

High Impact Severity: (Green or Yellow)

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

High Impact Severity: (Yellow)

“J, K, and L” Level findings:

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

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: Above & Beyond, Inc. - Metro Region
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living) & Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Routine Survey
Date of Survey: May 18 – 21, 2009

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<p>Tag # 1A09 Medication Delivery (MAR)</p> <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>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <p>(a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is</p>	<p>Scope and Severity Rating: E</p> <p>Medication Administration Records (MAR) were reviewed for the months of February, March & April 2009.</p> <p>Based on record review, 6 of 8 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #1 March 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Abilify 20mg (1 time daily) <p>April 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Abilify 20mg (1 time daily) <p>Individual #2 February 2009 Medication Administrative Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Abilify 5mg (1 time daily) • Sertraline HCL 100MG (1 time daily) • Cymbalta 60mg (1 time daily) • Polyethylene Glycol 17gm (1 time daily) 		

<p>prescribed;</p> <p>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p> <p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <p>(i) Name of resident;</p>	<ul style="list-style-type: none"> • Fluticasone 50mg (1 time daily) <p>March 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Miralax Powder (1 time daily) • Benefiber Clear Powder (3 times daily) • Zegerid 40 mg (1 time daily) • Abilify 5mg (1 time daily) • Cymbalta 60mg (1 time daily) <p>April 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Cymbalta 60mg (1 time daily) • Fosamax 70mg (1 time daily) • Benefiber Clear Powder (3 times daily) • Zegerid 40mg (1 time daily) • Abilify 5mg (1 time daily) • Miralax Powder (1 time daily) • Citrucel Powder (3 times daily) <p>Individual #3 February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Prevent 5000 Plus Cream (1 time daily) • Fluoxetine 20mg (1 time daily) • Seroquel 200mg (1 time daily) <p>Medication Administration Record did not contain the time the medication should be given. MAR indicated time as "AM":</p> <ul style="list-style-type: none"> • Seroquel 200mg (1 time daily) <p>March 2009 Medication Administration Records did not</p>		
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<ul style="list-style-type: none"> (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. <p>Model Custodial Procedure Manual D. Administration of Drugs</p> <p>Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> ➤ symptoms that indicate the use of the medication, ➤ exact dosage to be used, and ➤ the exact amount to be used in a 24 hour period. 	<p>contain the diagnosis for the medication is prescribed:</p> <ul style="list-style-type: none"> • Prevident 5000 Plus Cream (1 time daily) • Fluoxetine 20mg (1 time daily) • Seroquel 200mg (1 time daily) <p>April 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Seroquel 200mg (1 time daily) • Fluoxetine 20mg (1 time daily) • Ginkgo Biloba 60mg (1 time daily) <p>Individual #4 February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Lithium Carbonate 300mg (2 times daily) <p>March 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Lithium Carbonate 300mg (2 times daily) <p>April 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Lithium Carbonate 300mg (2 times daily) <p>Individual #5 February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Gentamicin 0.1% Cream (1 time daily) 		
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	<p>Individual #6 February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Concerta 36mg (1 time daily) <p>March 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Concerta 36mg (1 time daily) <p>April 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Concerta 36mg (1 time daily) 		
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Tag # 1A09 Medication Delivery - PRN	Scope and Severity Rating: E		
<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>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ul style="list-style-type: none"> (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and 	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 3 of 8 Individuals.</p> <p>Individual #1 February 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Acetaminophen 325mg (PRN) • Acetaminophen 500mg (PRN) <p>March 2009 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Acetaminophen 325mg (PRN) • Acetaminophen 500mg (PRN) <p>April 2009 Medication Administration Records did not contain the circumstance for which the medication is to be given:</p> <ul style="list-style-type: none"> • Ibuprofen 800mg (PRN) <p>Individual #2 February 2009 Medication Administration Records did not contain the circumstance for which the medication is to be given:</p> <ul style="list-style-type: none"> • Milk of Magnesia (PRN) • Prevident 5000 Plus Cream (PRN) <p>March 2009 Medication Administration Records did not contain the circumstance for which the medication is to be given:</p> <ul style="list-style-type: none"> • Milk of Magnesia (PRN) • Miralax Powder (PRN) 		

<p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006</p> <p>F. PRN Medication</p> <p>3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This</p>	<p>April 2009 Medication Administration Records did not contain the circumstance for which the medication is to be given:</p> <ul style="list-style-type: none"> • Preident 5000 Plus Cream (PRN) <p>Individual #5 April 2009 Medication Administration Records did not contain the circumstance for which the medication is to be given:</p> <ul style="list-style-type: none"> • Gentamicin 0.01% Cream (PRN) 		
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does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.

**NMAC 16.19.11.8 MINIMUM STANDARDS:
A. MINIMUM STANDARDS FOR THE
DISTRIBUTION, STORAGE, HANDLING AND
RECORD KEEPING OF DRUGS:**

(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications**. This documentation shall include:

- (i) Name of resident;
- (ii) Date given;
- (iii) Drug product name;
- (iv) Dosage and form;
- (v) Strength of drug;
- (vi) Route of administration;
- (vii) How often medication is to be taken;
- (viii) Time taken and staff initials;
- (ix) Dates when the medication is discontinued or changed;
- (x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual

D. Administration of Drugs

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications.

Document the practitioner's order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

Tag # 1A11 (CoP) Transportation Training	Scope and Severity Rating: D		
<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>G. Transportation: Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and procedures must address at least the following topics:</p> <ol style="list-style-type: none"> (1) Drivers' requirements, (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (3) Vehicle maintenance and safety inspections, (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures, (5) Emergency Plans, including vehicle evacuation techniques, (6) Documentation, and (7) Accident Procedures. <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy</p>	<p>Based on record review, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 2 of 26 Direct Service Personnel.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> • Transportation (DSP #54 & 65) 		

Training Requirements for Direct Service Agency
Staff Policy **Eff Date:** March 1, 2007

II. POLICY STATEMENTS:

I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:

1. Operating a fire extinguisher
2. Proper lifting procedures
3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat)
4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff's role)
6. Wheelchair tie-down procedures (if applicable to the staff's role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>E. 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>(1) Documentation of nursing assessment activities (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: (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. (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</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 3 of 8 Individual.</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Medication Administration Assessment Tool (#7) • Crisis Plans <ul style="list-style-type: none"> • Cardiac Condition <ul style="list-style-type: none"> ◦ Individual #4 – As indicated by the IST section of the ISP the individual is required to have a Medical Crisis Prevention/Intervention Plan. • Aspiration <ul style="list-style-type: none"> ◦ Individual #5 - As indicated by the IST section of ISP the individual is required to have an Aspiration plan. • Allergies <ul style="list-style-type: none"> ◦ Individual #5 - As indicated by the IST section of ISP the individual is required to have an Allergy plan. 		

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 caregiver upon request.

(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.

(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).

(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 *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

(2) Health related plans

(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.

(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.

(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.

(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.

(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):

(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.

(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.

(c) Approaches described in the plan shall be individualized to reflect the individual's unique

<p>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> <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</p>			
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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.

Tag # 1A20 DSP Training Documents	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>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> <p>(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</p> <p>(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>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 8 of 26 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"> • Pre- Service (DSP #64) • Person-Centered Planning (1-Day) (DSP #64) • First Aid (DSP #43, 49 & 64) • CPR (DSP #42, 49 & 64) • Assisting With Medications (DSP #52) • Rights & Advocacy (DSP #50) • Level 1 Health (DSP #54 & 59) • Teaching & Support Strategies (DSP #54) • Positive Behavior Supports Strategies (DSP #59) 		

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D		
<p>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</p> <p>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: 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.</p> <p>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: A. homicide; B. trafficking, or trafficking in controlled substances; C. kidnapping, false imprisonment, aggravated assault or aggravated battery; D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; E. crimes involving adult abuse, neglect or financial exploitation; F. crimes involving child abuse or neglect; G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</p>	<p>Based on record review, the Agency failed to maintain documentation 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 4 of 27 Agency Personnel.</p> <p>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</p> <ul style="list-style-type: none"> • #65 – Date of hire 11/21/2006 <p>The following Agency Personnel Files contained Caregiver Criminal History Screenings, which were not specific to the Agency:</p> <ul style="list-style-type: none"> • #44 – Date of hire 08/19/2005 • #49 – Date of hire 08/08/2008 • #67 – Date of hire 08/01/2005 		

H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.

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Chapter 1.IV. General Provider Requirements.

D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: D		
<p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>A. Duty To Report:</p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</p> <p>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</p> <p>B. Notification: (1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.</p>	<p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 8 individuals.</p> <p>Individual #2</p> <ul style="list-style-type: none"> Incident date 10/01/2008. Allegation was Abuse/Neglect. Incident report was received 09/30/2008. Failure to Report. IMB Late & Failure Report indicated incident was "Neglect Confirmed." 		

Tag # 5144 AH Reimbursement	Scope and Severity Rating: A		
<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 Services is in 15-minute increments hour. The rate is based on the individual's level of care.</p> <p>B. Billable Activities</p> <p>(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.</p> <p>(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</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 1 of 8 individuals.</p> <p>Individual #6 March 2009</p> <ul style="list-style-type: none"> The Agency billed 485 units of Adult Habilitation on 03/01/2009 through 03/31/2009. Documentation received accounted for 449 units. 		

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</p> <p>G. Health Care Requirements for Community Living Services.</p> <p>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first.</p> <p>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For</p>	<p>Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 3 of 8 individuals receiving Community Living Services.</p> <ul style="list-style-type: none"> • Auditory Exam <ul style="list-style-type: none"> ◦ Individual #5 - As indicated by the documentation reviewed, exam was scheduled for 3/28/2009. No evidence found to verify visit was completed. • Cholesterol <ul style="list-style-type: none"> ◦ Individual #6 - As indicated by the documentation reviewed, the exam was ordered on 11/26/2008. No evidence of exam was found. • Blood Glucose <ul style="list-style-type: none"> ◦ Individual #6 - As indicated by the documentation reviewed, the exam was ordered on 11/26/2008. No evidence of exam was found. • Blood Levels <ul style="list-style-type: none"> ◦ Individual #6 - As indicated by the documentation reviewed, the exam was ordered on 11/26/2008. No evidence of exam was found. 		

<p>Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p> <p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p>			
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Tag # 6L14 Residential Case File	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:</p> <p>(1) Complete and current ISP and all supplemental plans specific to the individual;</p> <p>(2) Complete and current Health Assessment Tool;</p> <p>(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</p> <p>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 5 of 8 Individuals receiving Supported Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Did not contain Pharmacy Information (#1, 3, 4, 5 & 6) • Annual ISP (#6) • ISP Signature Page (#1 & 6) • Addendum A (#1 & 6) • Individual Specific Training (Addendum B) (#6) • Teaching & Support Strategies (#6) • Positive Behavioral Plan (#5 & 6) • Positive Behavioral Crisis Plan (#5 & 6) • Occupational Therapy Plan (#6) • Health Assessment Tool (#3) • Crisis Plan <ul style="list-style-type: none"> ◦ Cardiac Condition (#4) • Progress Notes written by DSP and/or Nurses regarding Health Status: <ul style="list-style-type: none"> ◦ Individual #6 - None found for April 2009 and May 1 – 19, 2009 		

<p>response to identified changes in condition for at least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. <p>(10) Record of visits to healthcare practitioners</p>			
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including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and
(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living)	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>L. Residence Requirements for Family Living Services and Supported Living Services</p> <p>(1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has:</p> <ul style="list-style-type: none"> (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but 	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 3 of 8 Supported Living Residences.</p> <p>The following items were not found, not functioning or incomplete:</p> <ul style="list-style-type: none"> • Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift (#1, 4 & 6) 		

are not limited to, fire, chemical and/or hazardous waste spills, and flooding.