Date: April 29, 2010

To: Jessica Martinez, Director
Provider: Active Solutions, Inc.
Address: 2730 San Pedro NE Suite H
State/Zip: Albuquerque, New Mexico 87110

CC: Todd D. Johnson, President
Address: 2730 San Pedro NE Suite H
State/Zip Albuquerque, NM 87110

E-mail Address: jessicamartinez@activesolutionsinc.com

Region: Metro
Original Survey Date: April 13 – 16, 2009
Verifications Survey Date: April 12 – 13, 2010
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Family Living & Independent Living) & Community Inclusion (Adult Habilitation & Community Access)
Survey Type: Verification
Team Leader: Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Tony Fragua, BFA Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Cynthia Nielsen, MSN, RN, ONC, CCM, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Ms. Martinez,

The Division of Health Improvement Quality Management Bureau has completed a Plan of Correction Follow-up survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI/DDSD regarding the ***Routine Survey on April 13 - 16, 2009.***

These findings will be reviewed by the DOH – Internal Review Committee during an upcoming review meeting. The findings are attached.

Please call the Team Leader at 505-670-6290, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Nadine Romero, LBSW

Nadine Romero, LBSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	April 12, 2010
Present:	**Active Solutions, Inc** Todd D. Johnson, President **DOH/DHI/QMB** Nadine Romero, LBSW, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Cynthia Nielsen, MSN, RN, ONC, CCM, Healthcare Surveyor
Exit Conference Date:	April 14, 2010
Present:	**Active Solutions, Inc** Todd D. Johnson, President Jessica Martinez, Director **DOH/DHI/QMB** Nadine Romero, LBSW, Team Lead/Healthcare Surveyor Cynthia Nielsen, MSN, RN, ONC, CCM, Healthcare Surveyor **DDSD - Metro Regional Office** Selma Dodson, Community Inclusion Coordinator
Homes Visited	Number: 2
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 17 0 - Jackson Class Members 11 - Non-Jackson Class Members 8 - Family Living 4 - Adult Habilitation 12 - Community Access
Records Reviewed (Persons Served)	Number: 17
Administrative Files Reviewed	• Billing Records • Medical Records • Personnel Files • Training Records • Caregiver Criminal History Screening Records • Employee Abuse Registry

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

Attachment B

QMB Scope and Severity Matrix of survey results

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

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

Scope and Severity Definitions:

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

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

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

Key to 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.

The QMB Approval Rating

The QMB approval rating is the provider incentive to encourage quality service and correlates the review outcome with the QMB review frequency and its recommendation to DDSD to determine the length of the provider agreement. The "Approval rating" is based on the Scope and Severity of the review findings. There are five levels of "Approval" that a provider may receive. They are:

"Quality" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Quality" Rating. To qualify for a QMB "Quality" rating of approval" and a three (3) year QMB review cycle and provider agreement recommendation, the provider must not have any findings that are a condition of participation and no findings of "F" level or higher on the Scope and Severity Matrix with no more that three (3) D or E level findings.

"Merit" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Merit" Rating. To qualify for a QMB "Merit" rating of approval" and a two (2) year QMB review cycle and provider agreement recommendation, the provider must not have more than three (3) findings that are a condition of participation and no more than three (3) "F" level findings with no findings of a "G" level or higher on the Scope and Severity Matrix and no more that six (6) D or E level findings.

"Standard" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider qualifies for a "Standard" Rating. To qualify for a QMB "Standard" rating of approval" and a one (1) year QMB review cycle and provider agreement recommendation, the provider must not have more than six (6) findings that are a condition of participation and no more than six (6) "F" level findings with no findings of a "G" level or higher on the Scope and Severity Matrix and no more that six (6) D or E level findings.

"Sub-Standard" Approval Rating:
The QMB DD Manager will review the Report of Findings and determine if the provider has "Sub-standard" performance. To qualify for a QMB "Sub-Standard" rating of approval" and a three to six month QMB review cycle, with a referral to the Internal Review Committee and provider agreement recommendation, the provider may have any of the following findings:

- seven (7) or more findings that are a condition of participation
- seven (7) or more "F" level findings
- any findings of a "G" level or higher
- nine (9) or more D or E level findings

A referral to the IRC is required for any "Sub-standard" rating. Depending upon the egregious nature of the findings the IRC shall take appropriate sanction actions up to and including contract termination.

"Provisional" Approval Rating:
New DD service providers may qualify for a QMB "Provisional" Approval Rating upon successfully completing their initial QMB Quality Survey.
The QMB DD Manager will review the Report of Findings and determine if the provider has achieved at least a standard rating of approval. If successful, the provider may receive a one (1) year contract extension. QMB will notify the DDSD Contract unit of the "Provisional" approval rating.

Attachment C

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

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

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

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

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received in 10 days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed by the survey team.
- Providers must continue to complete their plan of correction during the IRF process
- Providers may not request an IRF to challenge the Scope and Severity of a finding.
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition
- Providers may not request an IRF to challenge the QMB Quality Approval Rating and the length of their DDSD provider contract.

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

QMB has 30 working days to complete the review and notify the provider of the decision. The request will be reviewed by the IRF committee. The Provider will be notified in writing of the ruling, no face to face meeting will be conducted.

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is successfully reconsidered, it will be noted and will be removed or modified from the report. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.

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: **Active Solutions, Inc., - Metro Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Family Living & Independent Living) & Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Verification Survey
Date of Original Survey: **April 13 - 16, 2009**
Date of Verification Survey: **April 12 – 14, 2010**

Statute	April 13 - 16, 2009 Deficiency	April 12 - 14, 2010 Verification Survey - New and Repeat Deficiencies
Tag # 1A08 Agency Case File	**Scope and Severity Rating: A**	**Scope and Severity Rating: NA**
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 1 of 18 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Positive Behavioral Plan (#18) • Positive Behavior Crisis Plan (#18)	Complete

telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.		

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E	Scope and Severity Rating: D
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **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. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (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 (f) For PRN medication, an explanation for the	Medication Administration Records (MAR) were reviewed for the months of January, February and March, 2009. The following MARs contained missing medications entries and/or other errors: Based on record review, 6 of 8 individuals had Medication Administration Records, which contained missing medications entries and /or other errors: Individual # 3 December 2008 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Tegretol 400 mg (2 times daily) • Phenobarbital 75 mg (1 time daily) • Phenobarbital 90 mg (1 time daily) • Ocuflox Eye drop (1 time daily) • Ciloxan (1 time daily) • Prevident Tooth Gel (1 time daily) • Nasonex Nasal Spray (1 time daily) • Metamucil 5 mg (2 times daily) • Lactulose 15 cc (2 times daily) • Prozac 10 mg (1 time daily) • Astelin Nasal Spray (1 time daily) January 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Tegretol 400 mg (2 times daily) • Phenobarbital 75 mg (1 time daily) • Phenobarbital 90 mg (1 time daily) • Ocuflox Eye drop (1 time daily) • Ciloxan (1 time daily) • Prevident Tooth Gel (1 time daily) • Nasonex Nasal Spray (1 time daily) • Metamucil 5 mg (2 times daily) • Lactulose 15 cc (2 times daily)	**Repeat Finding:** Medication Administration Records (MAR) were reviewed for the months of February 2010. The following MARs contained missing medications entries and/or other errors: Based on record review, 1 of 7 individuals had Medication Administration Records, which contained missing medications entries and /or other errors: Individual # 15 February 2010 Medication Administration Records did not contain the dosage for which the medication is prescribed: • Cephalexin (4 times daily until finished)

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. (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; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (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 administrating the medication, signs and symptoms of adverse events and interactions with other medications; **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.	• Prozac 10 mg (1 time daily) • Astelin Nasal Spray (1 time daily) February 2009 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Tegretol 400 mg (2 times daily) • Phenobarbital 75 mg (1 time daily) • Phenobarbital 90 mg (1 time daily) • Ocuflox Eye drop (1 time daily) • Ciloxan (1 time daily) • Prevident Tooth Gel (1 time daily) • Nasonex Nasal Spray (1 time daily) • Metamucil 5 mg (2 times daily) • Lactulose 15 cc (2 times daily) • Prozac 10 mg (1 time daily) • Astelin Nasal Spray (1 time daily) Individual # 9 December 2008 Medication Administration Record does not contain a full signature that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following: • Topamax 100 mg (2 times daily) • Dilantin 100 mg (2 times daily) • Klonopin 0.5 mg (2 times daily) • Actonel 35 mg (take one every Tuesday) No time taken indicated on the Medication Administration Record document for the following medication, MAR indicated time as “A.M.”: • Klonopin 0.5 mg (2 times daily) January 2009 Medication Administration Record does not contain a full signature that designates the full name that corresponds to each initial used to	

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.	document administered or assisted delivery of each dose for the following: • Topamax 100 mg (2 times daily) • Dilantin 100 mg (2 times daily) • Klonopin 0.5 mg (2 times daily) • Actonel 35 mg (take one every Tuesday) No time taken indicated on the Medication Administration Record document for the following medication, MAR indicated time as "A.M.": • Klonopin 0.5 mg (2 times daily) Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Topamaz 100 mg (2 times daily) - Blank - January 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 26, 27, 28, 29, 30 & 31 (6 AM) February 2009 Medication Administration Record does not contain a full signature that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following: • Topamax 100 mg (2 times daily) • Dilantin 100 mg (2 times daily) • Klonopin 0.5 mg (2 times daily) • Actonel 35 mg (take one every Tuesday) Individual # 10 December 2008 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Ibuprofen 600 mg (3 times daily for 10 days) January 2009 Medication Administration Records did not contain the diagnosis for which the medication is	

	prescribed: • Doxcycline 100 mg (2 times daily for 10 days) Individual # 15 December 2008 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Pepcid 20 mg (Take every 12 hours until finished) • Prednizone 10 mg Medication Administration Record indicated medication was to taken as follows: • Prednizone 10 mg (2 tablets daily for 3 days, then 1 tablet daily for 3 days) Per Physician orders medication is to be takes as follows: 6 tablets daily for 3 days, then 4 tablets daily for 3 days , then 2 tablets daily for 3 days & finally 1 tablet daily for 3 days. MAR and Physician orders do not match. Individual # 16 December 2008 Medication Administration Record indicated medication had not been given as prescribed: • Ibuprofen 800 mg – 3 times daily for 7 days. MAR only contained dates for 6 days. December 3, 4, 5, 6, 7 & 28. • Ciprofloxacin 500 mg – 2 times daily for 10 days. MAR indicated the individual was given an extra dose on December 15, 2008. January 2009 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Citalopram - 40 mg - Blank - January 3, 4 & 5 (9AM) • Citalopram - 20 mg - Blank - January 3 & 4 (1PM)	

	• Citalopram 10 mg - Blank - January 3 & 4 (1PM) Medication Administration Record indicated medication had not been given as prescribed: • Ibuprofen 800 mg – 3 times daily for 7 days. MAR indicated medication had been give for 9 days**:** January 23, 24, 25, 26, 27, 28, 29, 30 & 31 Individual # 17 December 2008 Medication Administration Records did not contain the route of administration for the following medications: • Topamax 200 mg - 2 times daily Medication Administration Records did not contain diagnosis for which the medication is prescribed: • Topamax 200 mg - 2 times daily	

Tag # 1A09 Medication Delivery - PRN Medication	Scope and Severity Rating: E	Scope and Severity Rating: D
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **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. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (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 (f) For PRN medication, an explanation for the	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 4 of 8 Individuals. Individual # 4 December 2008 No symptoms noted on the Medication Administration Record for the following PRN medication: • Tylenol (PRN) - December 1 & 5, 2008. • Benadryl (PRN) – December 2, 9 &17, 2008 No effectiveness noted on the Medication Administration Record for the following PRN medication: • Tylenol (PRN) – December 1 & 5, 2008. • Benadryl (PRN) – December 2, 9 &17, 2008 February 2009 No symptoms noted on the Medication Administration Record for the following PRN medication: • Benadryl (PRN) – February 18, 19, 22 & 23, 2009 Individual # 9 December 2008 Medication Administration Record does not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose: • Ativan - 2mg (PRN) January 2009 Medication Administration Record document does not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose: • Ativan - 2mg (PRN)	**Repeat Finding:** Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 1 of 7 Individuals. Individual # 16 February 2010 No symptoms noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 800 mg (PRN) - (1st dose) 2/7, 9, 17 & 24; (2nd dose) 2/3, 4, 5, 7, 8, 17, 18 & 24 & (3rd dose) 2/3, 4, 5, 6, 7, 8, 9, 17, 18 & 24 • Hydrocodone 500 mg (PRN) - (1st dose) 2/10 & 11 No effectiveness noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 800 mg (PRN) - (1st dose) 2/7, 9, 17 & 24; (2nd dose) 2/3, 4, 5, 7, 8, 17, 18 & 24 & (3rd dose) 2/3, 4, 5, 6, 7, 8, 9, 17, 18 & 24 • Hydrocodone 500 mg (PRN) - (1st dose) 2/10 & 11 No specific time(s) noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 800 mg (PRN) - (1st dose) 2/7, 9, 17 & 24; (2nd dose) 2/3, 4, 5, 7, 8, 17, 18 & 24 & (3rd dose) 2/3, 4, 5, 6, 7, 8, 9, 17, 18 & 24 • Hydrocodone 500 mg (PRN) - (1st dose) 2/10 & 11

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. (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; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (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 administrating the medication, signs and symptoms of adverse events and interactions with other medications; **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;	February 2009 Medication Administration Record document does not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose: • Ativan - 2mg (PRN) Individual # 15 December 2008 Medication Administration Records did not contain the circumstance in which the medication is to be given: • Hydroxyzine 25mg (PRN) Individual # 16 December 2008 No effectiveness noted on the Medication Administration Record for the following PRN medication: • Phenazopyridine 200mg (PRN) - December 5, 6, 7, 8 & 9	

(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. **Department of Health** **Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 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 does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating		

use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN 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. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN		

Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).		

Tag # 1A12 Reimbursement/Billable Units	Scope and Severity Rating: NA	Scope and Severity Rating: A
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.		**New Finding** Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed, which contained the required information for 1 of 3 individuals. Individual #3 February 2010 • The Agency billed a total of 572 units of Adult Habilitation on February 1 through 26, 2010. Documentation provided did not contain a description of what occurred during the encounter or service interval on February 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 2010, to justify billing.

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: D	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **Chapter 1. III. E. (1 - 4) (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 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.	Based on record review the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 18 individuals. The following were not found or not current: • Medication Administration Assessment Tool (#6) • Crisis Plans ◦ Cardiac condition (#6) (Per IST section of the ISP the individual requires a crisis plan) ◦ Seizures (#9) (Per IST section of the ISP the individual requires a crisis plan) ◦ Asthma (#9) (Per IST section of the ISP the individual requires a crisis plan) ◦ Allergy (#9) (Per IST section of the ISP the individual requires a crisis plan)	Complete

(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 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. (d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions. (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. (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization. (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. (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed. **(4) General Nursing Documentation** (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. (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.		

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E	Scope and Severity Rating: D
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE 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. **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: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH)** Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 25 of 65 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #83, 88, 97, 101, 102, 107, 108, 109, 113 & 114) • Basic Health/Orientation (DSP #70, 88, 89, 97, 101, 102, 108, 109, 112, 113 & 114) • Person-Centered Planning (1-Day) (DSP #70, 76, 100, 105, 109, 113 & 114) • First Aid (DSP # 61, 65& 114) • CPR (DSP # 65 & 114) • Assisting With Medications (DSP #51, 54, 57 & 93) • Rights & Advocacy (DSP #103, 105, 109, 112-& 113) • Level 1 Health (DSP #73, 103, 105, 109, 111, 112 &113) • Teaching & Support Strategies (DSP #73, 103, 105, 109 & 113) • Positive Behavior Supports Strategies (DSP #103, 105, 109, 111 & 113) • Participatory Communication & Choice Making (DSP #73, 103, 105, 109, 112 & 113)	**Repeat & New Finding:** Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 5 of 64 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #129 & 134) • Basic Health/Orientation (DSP #129) • Person-Centered Planning (1-Day) (DSP #131) • First Aid (DSP #72) • CPR (DSP #72) • Positive Behavior Supports Strategies (DSP #125) • Participatory Communication & Choice Making (DSP #125)

individual service plan (ISP) of each individual served. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines. F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001. I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services.		

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D	Scope and Severity Rating: NA
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. **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. **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 **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.	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 7 of 71 Agency Personnel. • # 53 – Date of Hire 10/24/06 • # 87 – Date of Hire 9/22/08 • # 93 – Date of Hire 3/15/07 • # 115 – Date of Hire 12/18/06 • # 116 – Date of Hire 7/31/06 • # 118 – Date of Hire 10/15/07 • # 120 – Date of Hire 7/15/08	Complete

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E	Scope and Severity Rating: NA
NMAC 7.1.12.8 **REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED**: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals	Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced the inquiry to the Employee Abuse Registry prior to employment for 37 of 71 Agency Personnel. • #50 - Date of Hire 10/20/06 • #51 - Date of Hire 8/31/07 • #55 - Date of Hire 3/15/07 • #56 - Date of Hire 7/1/08 • #58 - Date of Hire 12/1/07 • #59 - Date of Hire 31/1/07 • #60 - Date of Hire 5/30/07 • #62 - Date of Hire 11/2/06 • #63 - Date of Hire 3/30/07 • #65 - Date of Hire 8/3/07 • #66 - Date of Hire 3/6/08 • #69 - Date of Hire 11/1/06 • #70 - Date of Hire 11/5/08 • #71 - Date of Hire 3/27/07 • #72 - Date of Hire 2/8/08 • #73 - Date of Hire 10/1/07 • #74 - Date of Hire 4/2/08 • #76 - Date of Hire 4/30/08 • #77 - Date of Hire 9/1/08 • #78 - Date of Hire 7/31/08 • #79 - Date of Hire 5/1/06 • #80 - Date of Hire 12/7/07 • #81 - Date of Hire 1/4/07 • #82 - Date of Hire 1/28/06 • #91 - Date of Hire 2/14/06 • #93 - Date of Hire 3/15/07 • #95 - Date of Hire 4/1/09 • #96 - Date of Hire 3/14/08 • #98 - Date of Hire 7/1/06 • #104 - Date of Hire 6/18/08 • #105 - Date of Hire 1/8/08 • #109 - Date of Hire 3/15/07 • #114 - Date of Hire 5/15/08	Complete

providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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.	• #116 - Date of Hire 12/18/06 • #118 - Date of Hire 10/15/07 • #120 - Date of Hire 7/15/08	

Tag # 1A28 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: D	Scope and Severity Rating: NA
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007** **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.	Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 2 of 71 Agency Personnel. • Abuse, Neglect & Exploitation (#96) When DSP were asked what two State Agencies is suspected Abuse, Neglect and Exploitation reported to, the following was reported: • DSP #105 stated, “Fill out form, call team.” DSP did not identify they are required to report the Adult Protective Service and/or the Division of Health Improvement.	Complete

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE 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. **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: (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. **Department of Health (DOH)** **Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** **A.** Individuals shall receive services from competent and qualified staff. **B.** Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.	Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 5 of 71 Agency Personnel. • Individual Specific Training (#81, 83, 85, 92 & 97)	Complete

Tag # 5I36 CA Reimbursement	Scope and Severity Rating: B	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS** **G. Reimbursement** (1) Billable Unit**:** A billable unit is defined as one-quarter hour of service. (2) Billable Activities**:** The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan; (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and (c) Non face-to-face hours do not exceed 10% of the monthly billable hours. (3) Non-Billable Activities**:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include: (a) Time and expense for training service personnel; (b) Supervision of agency staff; (c) Service documentation and billing activities; or (d) Time the individual spends in segregated facility-based settings activities.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for 3 of 13 individuals receiving Community Access Services. Individual # 1 • January 2009 - Agency billed 88 units of Community Access. Documentation received accounted for 64 units. Individual # 8 • February 2009 - Agency billed 16 units of Community Access. No documentation found to justify billing. Individual # 15 • December 2008 - Agency billed 140 units of Community Access. Documentation received accounted for114 units. • January 2009 - Agency billed 182 units of Community Access. Documentation received accounted for 162 units.	Complete

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: F	Scope and Severity Rating: NA
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **A. Support to Individuals in Family Living:** The Family Living Services Provider Agency shall provide and document: (5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include: (a) Review, advise, and prompt the implementation of the individual's ISP Action Plans, schedule of activities and appointments; and (b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members. **B. Home Studies**. The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS** **D. Scope of DDSD Agreement**	Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 7 of 8 individuals. • DDSD Approval for Subcontractor (#3, 4, 9, 10, 15, 16 & 17)	Complete

(4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite; **NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER** **ELIGIBLE PROVIDERS:** I. **Qualifications for community living service providers:** There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards. (1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.		

Tag # 6L14 Residential Case File	Scope and Severity Rating: E	Scope and Severity Rating: NA

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007
CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS
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:
(1) Complete and current ISP and all supplemental plans specific to the individual;
(2) Complete and current Health Assessment Tool;
(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;
(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);
(5) Data collected to document ISP Action Plan implementation
(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;
(7) Physician's or qualified health care providers written orders;
(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);
	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 2 of 8 Individuals receiving Family Living Services.
	• Current Emergency & Personal Identification
	  • Not Current (#4)
	  • No Pharmacy Identified (#16)
	• Addendum A (#16)
	• Speech Therapy Plan (#4)
	• Health Care Providers Written Orders (#16)
		Complete

(9) Medication Administration Record (MAR) for the past three (3) months which includes: (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: (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. (10) Record of visits to healthcare practitioners 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…		