



SUSANA MARTINEZ, GOVERNOR

CATHERINE D. TORRES, M.D., CABINET SECRETARY

Date: September 26, 2011

To: Lucy Aguilar, Executive Director
Provider: Alternative Personal Care, LLC
Address: 1215 Anthony Drive, Suite A
State/Zip: Anthony, New Mexico

E-mail Address: alucy3761@yahoo.com

Region: Southwest
Survey Date: August 8 - 10, 2011
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Independent Living & Family Living) & Community Inclusion (Adult Habilitation & Community Access)

Survey Type: Routine
Team Leader: Stephanie R. Martinez de Berenger, M.P.A., GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Zack Robinson, LBSW, Developmental Disabilities Supports Division

Dear Ms Aguilar:

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider contracts. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Quality Management Compliance Determination:

The Division of Health Improvement is issuing your agency a determination of %Substandard Compliance with Conditions of Participation.+

Plan of Correction:

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

- 1. Quality Management Bureau, Attention: Plan of Correction Coordinator
5301 Central Ave. NE Suite 400 Albuquerque, NM 87108**
- 2. Developmental Disabilities Supports Division Regional Office for region of service surveyed**



DIVISION OF HEALTH IMPROVEMENT • QUALITY MANAGEMENT BUREAU
5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
(505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

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Survey Report #: Q12.01.85452220.SW.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 business days. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as all remedies must still be completed within 45 business days of the receipt of this letter.

Failure to submit, complete or implement your Plan of Correction within the 45 day required time frames may result in the imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Request for Informal Reconsideration of Findings (IRF):

If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

QMB Deputy Bureau Chief
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request

See Attachment %G+for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 business days. Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator at 505-222-8647 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Stephanie R. Martinez de Berenger, M.P.A., GCDF

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

Survey Process Employed:

Entrance Conference Date: August 8, 2011

Present: **Alternative Personal Care, LLC**
Lucy Aguilar, Executive Director
Paulina Aguilar, Service Coordinator

DOH/DHI/QMB
Stephanie R. Martinez de Berenger, M.P.A, GCDF, Team
Lead/Healthcare Surveyor

DDSD – Southwest Regional Office
Zack Robinson, Social & Community Coordinator

Exit Conference Date: August 10, 2011

Present: **Alternative Personal Care, LLC**
Lucy Aguilar, Executive Director
Paulina Aguilar, Service Coordinator

DOH/DHI/QMB
Stephanie R. Martinez de Berenger, M.P.A, GCDF Team
Lead/Healthcare Surveyor

DDSD – Southwest Regional Office
Zack Robinson, Social & Community Coordinator

Total Homes Visited Number: 2

❖ Family Homes Visited Number: 2

Administrative Locations Visited Number: 1

Total Sample Size Number: 4
0 - *Jackson* Class Members
4 - Non-*Jackson* Class Members
2 - Family Living
1 - Independent Living
4 - Adult Habilitation
1 - Community Access

Persons Served Interviewed Number: 3

Persons Served Observed Number: 1 (Individual was not available during the on-site visit)

Person Served Records Reviewed Number: 4

Direct Service Professionals Interviewed Number: 7

Direct Service Professionals Record Review Number: 11

Service Coordinator Record Review Number: 1

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
- Evacuation Drills
- Quality Assurance / Improvement Plan

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

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

Introduction:

After a QMB Compliance Review, your QMB Report of Findings will be sent to you via US mail.

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

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

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-222-8647 or email at George.Perrault@state.nm.us. Requests for technical assistance must be requested through your DDS Regional Office.

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

Instructions for Completing Agency POC:

Required Content

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan. (see page 3, DDW standards, effective; April 1, 2007, Chapter 1, Section I Continuous Quality Management System)

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

The Plan of Correction you submit needs to address **each deficiency** in the two right hand columns with:

1. How the corrective action will be accomplished for all cited deficiencies in the report of findings;
2. How your Agency will identify all other individuals having the potential to be affected by the same deficient practice;
3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur and corrective action is sustained;
4. How your Agency plans to monitor corrective actions utilizing its continuous Quality Assurance/Quality Improvement Plan to assure solutions in the plan of correction are achieved and sustained, including (if appropriate):
 - Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
 - Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
 - Your processes for ensuring that all staff are trained in Core Competencies, Incident Reporting, and Individual-Specific service requirements, etc;
 - How accuracy in Billing documentation is assured;

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- How health, safety is assured;
- For Case Management Providers, how ISPs are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data, and
- Details about Quality Targets in various areas, current status, Root Cause Analyses about why Targets were not met, and remedies implemented.

5. The individual's title responsible for the Plan of Correction and completion date.

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

Completion Dates

The plan of correction must include a **completion date** (entered in the far right-hand column). Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 days.

Direct care issues should be corrected immediately and monitored appropriately. Some deficiencies may require a staged plan to accomplish total correction. Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Plan of Correction Submission Requirements

1. Your Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. If you have questions about the POC process, call the POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
 - a. Electronically at George.Perrault@state.nm.us
 - b. Faxed to 505-222-8661, or
 - c. Mailed to QMB, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not send supporting documentation to QMB until after your POC has been approved by QMB.
6. QMB will notify you when your POC has been ~~%~~approved+or ~~%~~denied.+
 - a. Whether your POC is ~~%~~approved,+or ~~%~~denied,+you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
 - b. If your POC is ~~%~~denied+it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
 - c. If your POC is ~~%~~denied+a second time your agency may be referred to the Internal Review Committee.
 - d. You will receive written confirmation that your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.
8. Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

POC Document Submission Requirements

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

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. You may submit your documents by postal mail, fax, or electronically on disc or scanned and attached to e-mails.
3. All submitted documents must be annotated: please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. For billing deficiencies, you must submit:
 - a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
 - b. Copies of void and adjust+forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

QMB Scope and Severity Matrix

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 Compliance Determination.

		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:

- **Isolated:**
A deficiency that is limited to 1% to 15% of the sample, usually impacting few 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 could be referred to the Internal Review Committee for review and possible actions or sanctions.

QMB Determinations of Compliance

- Substantial Compliance with Conditions of Participation

The QMB determination of Substantial Compliance with Conditions of Participation indicates that a provider is in substantial compliance with all Conditions of Participation and other standards and regulations. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Substantial Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation.

- Non-Compliance with Conditions of Participation

The QMB determination of Non-Compliance with Conditions of Participation indicates that a provider is out of compliance with one (1) or more Conditions of Participation. This non-compliance, if not corrected, is likely to result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety.

Providers receiving a repeat determination of Non-Compliance may be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- Sub-Standard Compliance with Conditions of Participation

The QMB determination of Sub-Standard Compliance with Conditions of Participation indicates a provider is significantly out of compliance with Conditions of Participation and/or has:

- Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
- Any finding of actual harm or Immediate Jeopardy.

Providers receiving a repeat determination of Substandard Compliance will be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

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

Introduction:

Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means 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. Providers may use the following process to informally dispute a finding.

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.
2. 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>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received within 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 or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.
- Providers may not request an IRF to challenge the QMB compliance determination or the length of their DDS provider contract.

A Provider forfeits the right to an IRF if the request is not made within 10 working days of receiving the report and/or 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 removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.

Agency: Alternative Personal Care, LLC - Southwest Region
Program: Developmental Disabilities Waiver
Service: Community Living (Family Living & Independent Living) & Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Routine Survey
Date of Survey: August 8 – 10, 2011

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<p>Tag # 1A03 CQI System</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS</p> <p>I. Continuous Quality Management System: Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to:</p> <ol style="list-style-type: none"> (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and 	<p>Scope and Severity Rating: C</p> <p>Based on record review, the Agency failed to develop and implement a Continuous Quality Management System.</p> <p>Review of the Agency's Continuous Quality Improvement Plan provided during the August 8 . 10, 2011 on-site survey did not contain the components required by Standards.</p> <p>The Agency's CQI Plan did not contain the following components:</p> <ol style="list-style-type: none"> (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <p>]</p>	<p>[]</p>

- coordination of healthcare supports at both supervisory and direct support levels;
- (6) Quality and completeness documentation; and
- (7) Trends in individual and guardian satisfaction.

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

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

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

Tag # 1A08 Agency Case File	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <ol style="list-style-type: none"> (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the 	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 3 of 4 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Individual Specific Training Section of ISP (#4) • ISP Teaching & Support Strategies <ul style="list-style-type: none"> ◦ <i>Individual #3 - TASS not found for:</i> <ul style="list-style-type: none"> ◦ Outcome Statement # 2 <ul style="list-style-type: none"> ➢ % will take out materials needed+ ➢ % will wash the back of the vehicle+ ➢ % will wash the middle of vehicle+ ◦ Outcome Statement # 3 <ul style="list-style-type: none"> ➢ % will learn 1 traffic sign+ ◦ <i>Individual #4 - TASS not found for:</i> <ul style="list-style-type: none"> ◦ Outcome Statement # 1 <ul style="list-style-type: none"> ➢ % will decide what to work on+ ➢ % will purchase materials+ ➢ % will complete task+ ◦ Outcome Statement # 2 <ul style="list-style-type: none"> ➢ % will plan parties+ ➢ % will host party and take orders+ ➢ % will make Business cards to give out at the party+ ◦ Outcome Statement # 3 <ul style="list-style-type: none"> ➢ % find available activities events+ ➢ % choose an activity/event to participate in+ ➢ % go to and participate in chosen activity + • Positive Behavioral Plan (#1 & 4) • Positive Behavioral Crisis Plan (#1 & 4) 	<p>Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p>

- 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.

NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

Tag # 1A08.1 Agency Case File - Progress Notes	Scope & Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <p>(3) Progress notes and other service delivery documentation;</p>	<p>Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 2 of 4 Individuals.</p> <p>Family Living Progress Notes/Daily Contact Logs</p> <ul style="list-style-type: none"> • Individual #3 - None found for: <ul style="list-style-type: none"> ◦ April 4, 5, 6, 7, 8, 9, 10, 11, 12, 18, 19, 25 & 26, 2011. ◦ May 14, 15, 21, 22, 28 & 29, 2011. ◦ June 4, 5, 6, 7, 8, 9, 10, 11, 12, 18, 19, 25 & 26, 2011. <p>Independent Living Progress Notes/Daily Contact Logs</p> <ul style="list-style-type: none"> • Individual #4 - None found for: <ul style="list-style-type: none"> ◦ April 17 & 30, 2011 ◦ May 2, 3, 4, 5, 6, 9, 10, 11, 12, 13 & 14, 2011. ◦ June 19, 20, 21, 22, 23, 22 & 25, 2011. ◦ July 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 25, 26, 27, 28, 29 & 31, 2011. <p>Adult Habilitation Progress Notes/Daily Contact Logs</p> <ul style="list-style-type: none"> • Individual #3 . None found for April 1, 2011 & June 6, 7, 8, 9 & 10, 2011. • Individual #4 - None found for May 21, 2011 & June 25, 2011 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/> <p>]</p>	<p>[]</p>

Tag # 1A09 Medication Delivery (MAR) - Routine Medication	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 DDS 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 DDS Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <ol style="list-style-type: none"> 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; Prescribed dosage, frequency and method/route of administration, times and dates of administration; Initials of the individual administering or assisting with the medication; Explanation of any medication irregularity; Documentation of any allergic reaction or adverse medication effect; and 	<p>Medication Administration Records (MAR) were reviewed for the months of April, May & June 2011.</p> <p>Based on record review, 2 of 4 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #3 April 2011</p> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Omeprazole 20mg (2 times daily) • Bentyl 10mg (3 times daily) <p>Medication Administration Record document did 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 for the following medications:</p> <ul style="list-style-type: none"> • Omeprazole 20mg (2 times daily) • Bentyl 10mg (3 times daily) <p>May 2011</p> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Bentyl 10mg (3 times daily) <p>Medication Administration Record document did 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 for the following medications:</p> <ul style="list-style-type: none"> • Omeprazole 20mg (2 times daily) • Bentyl 10mg (3 times daily) 	<p>[]</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/> <p>]</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> <ul style="list-style-type: none"> (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 	<p>June 2011 Medication Administration Record document did 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 for the following medications:</p> <ul style="list-style-type: none"> • Omeprazole 20mg (2 times daily) • Bentyl 10mg (3 times daily) <p>Individual #4 April 2011 Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Ability 15mg (1 time daily) • Omega-3 Fish Oil 1200mg (3 times daily) • Phenytoin 100mg (3 times daily) • Phenytoin 200mg (2 times daily) • Divalproex 250mg (2 times daily) • Omeprazole 20mg (1 time daily) • Gemfibrozil 600mg (2 times daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Ability 15mg (1 time daily) • Omega-3 Fish Oil 1200mg (3 times daily) • Phenytoin 100mg (3 times daily) • Phenytoin 200mg (2 times daily) • Divalproex 250mg (2 times daily) 		
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<p>administering medications.</p> <p>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.</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. 	<ul style="list-style-type: none"> • Omeprazole 20mg (1 time daily) • Gemfibrozil 600mg (2 times daily) <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Ability 15mg (1 time daily) • Omega-3 Fish Oil 1200mg (3 times daily) • Divalproex 250mg (2 times daily) • Gemfibrozil 600mg (2 times daily) <p>May 2011 Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Ability 15mg (1 time daily) • Omega-3 Fish Oil 1200mg (3 times daily) • Phenytoin 100mg (3 times daily) • Phenytoin 200mg (2 times daily) • Divalproex 250mg (2 times daily) • Omeprazole 20mg (1 time daily) • Gemfibrozil 600mg (2 times daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Ability 15mg (1 time daily) 		
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	<ul style="list-style-type: none"> • Omega-3 Fish Oil 1200mg (3 times daily) • Phenytoin 100mg (3 times daily) • Phenytoin 200mg (2 times daily) • Divalproex 250mg (2 times daily) • Omeprazole 20mg (1 time daily) • Gemfibrozil 600mg (2 times daily) <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Ability 15mg (1 time daily) • Omega-3 Fish Oil 1200mg (3 times daily) • Divalproex 250mg (2 times daily) • Gemfibrozil 600mg (2 times daily) <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Triazidome (1 time daily) . Blank 5/29 • Omega-3 Fish Oil (3 times daily) . Blank 5/29 (12:00pm & 6:00pm) <p>June 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Phenytoin 200mg (3 times daily) . Blank 6/26 (7:00pm) <p>Medication Administration Records did not</p>		
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	<p>contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Ability 15mg (1 time daily) • Omega-3 Fish Oil 1200mg (3 times daily) • Phenytoin 100mg (3 times daily) • Phenytoin 200mg (2 times daily) • Divalproex 250mg (2 times daily) • Omeprazole 20mg (1 time daily) • Gemfibrozil 600mg (2 times daily) <p>Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:</p> <ul style="list-style-type: none"> • Ability 15mg (1 time daily) • Omega-3 Fish Oil 1200mg (3 times daily) • Pheytoin 100mg (3 times daily)(8:00 am) • Pheytoin 200mg (2 times daily) • Divalproex 250mg (2 times daily) • Omeprazole 20mg (1 time daily) • Gemfibrozil 600mg (2 times daily) <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Ability 15mg (1 time daily) • Omega-3 Fish Oil 1200mg (3 times daily) 		
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| | <ul style="list-style-type: none">• Divalproex 250mg (2 times daily)• Gemfibrozil 600mg (2 times daily) | | |
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Tag # 1A09.1 Medication Delivery - PRN Medication	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> <ol style="list-style-type: none"> 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; Prescribed dosage, frequency and method/route of administration, times and dates of administration; Initials of the individual administering or assisting with the medication; Explanation of any medication irregularity; 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 1 of 2 Individuals.</p> <p>Individual #4 May 2011</p> <p>No evidence of documented Signs/Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> • Triazodome 0.25 . PRN . 5/2, 7, 15 & 22 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Triazodome 0.25 . PRN . 5/1 (given 1 time) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Triazodome 0.25 (PRN) <p>June 2011</p> <p>No evidence of documented Signs/Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> • Triazodome 0.25 . PRN . 6/2, 7, 15, & 22 (given 1 time) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Triazodome 0.25 . PRN . 6/2, 7, 15, & 22 (given 1 time) <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> • Triazodome 0.25 (PRN) 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <p>]</p>	<p>[]</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> <ul style="list-style-type: none"> (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 			
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- 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.

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 # 1A11.1 (CoP) Transportation Training	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>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date: March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>1. 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:</p> <ol style="list-style-type: none"> 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) 	<p>Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 8 of 11 Direct Service Professionals.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> • Transportation (DSP #40, 41, 43, 44, 46, 48, 49 & 50) <p>When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:</p> <ul style="list-style-type: none"> • DSP#40 stated, "I did not have a transportation class." • DSP #46 stated, "No, not transportation." 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <p>]</p>

Tag # 1A15.2 & 5109 - Healthcare Documentation	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</p> <p>(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:</p> <ul style="list-style-type: none"> (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. <p>(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 4 of 4 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Electronic Comprehensive Health Assessment Tool (e-CHAT) or Health Assessment Tool (HAT)(#1) • Comprehensive Aspiration Risk Management Plan (CARMP) (#1, 2 ,3 & 4) • Aspiration Risk Screening Tool (ARST) (#2 & 4) 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/> <p>]</p>	<p>[[</p>

<p>agency nurse must be available to assist the caregiver upon request.</p> <p>(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first.</p> <p>(d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy).</p> <p>(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as <i>subjective</i> information including the individual complaints, signs and symptoms noted by staff, family members or other team members; <i>objective</i> information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); <i>assessment</i> of the clinical status, and <i>plan</i> of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p>(2) Health related plans</p> <p>(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare</p>			
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<p>professional.</p> <p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.</p> <p>(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.</p> <p>(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):</p> <p>(a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.</p> <p>(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.</p> <p>(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse . persons responsible for each intervention</p>			
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<p>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 with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p>			
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CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS

B. IDT Coordination

(1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and

(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.

Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010

F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:

1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance

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>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as %Addendum B+) training requirements in</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 6 of 11 Direct Service Professionals.</p> <p>Review of Direct Service Professionals 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 #41) • Foundation for Health & Wellness (DSP #40) • Person-Centered Planning (1-Day) (DSP #41) • First Aid (DSP #44 & 48) • CPR (DSP #44 & 48) • Assisting With Medication Delivery (DSP #47) • Participatory Communication & Choice Making (DSP #46 & 48) • Rights & Advocacy (DSP #46) • Positive Behavior Supports Strategies (DSP #46) • Teaching & Support Strategies (DSP #46 & 48) 	<p>Provider:</p> <p>In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p>	<p>]]</p>

accordance with the specifications described in the individual service plan (ISP) of each individual served.

C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.

D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.

E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.

F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.

G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.

H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.

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

Tag # 1A22 Staff Competence	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</p> <ol style="list-style-type: none"> (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy 	<p>Based on interview, the Agency failed to ensure that training competencies were met for 1 of 7 Direct Service Professionals.</p> <p>When DSP were asked if the individual had a Positive Behavioral Crisis Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #49 stated, %have not read the Positive Behavioral Plan.+ According to the Individual Specific Training Section of the ISP and the agency file, the individual has Positive Behavioral Crisis Plan. (Individual #4) 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/> <p>]</p>	<p>]]</p>

<p>Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and</p> <p>(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.</p> <p>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:</p> <p>(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p>			
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Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E		
<p>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.</p> <p>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.</p> <p>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.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employees 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.</p> <p>E. Documentation for other staff. With</p>	<p>Based on record review, the Agency failed to maintain documentation in the employees personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 4 of 11 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #42 . Date of hire 03/12/2009. Completed 01/04/2011. • #43 . Date of hire 10/12/2009. Completed 01/05/2011. • #44 . Date of hire 07/06/2010. Completed 01/04/2011. • #45 . Date of hire 07/25/2011. Completed 07/28/2011. 	<p>Provider:</p> <p>In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>	<p> </p>

respect to all employed or contracted individuals 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.

Tag # 1A28.1 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: E		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p> <p>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p>	<p>Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 8 of 12 Agency Personnel.</p> <p>Direct Service Professional Personnel (DSP):</p> <ul style="list-style-type: none"> Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (40, 41, 42, 44, 47, 48 & 49) <p>Service Coordination Personnel (SC):</p> <ul style="list-style-type: none"> Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#51) 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/> <p>]</p>	<p>[[</p>

Tag # 1A28.2 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: E		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p>E. Consumer and Guardian Orientation Packet: Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.</p>	<p>Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 3 of 4 individuals.</p> <ul style="list-style-type: none"> • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#1, 2 & 4) 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/> <p>]</p>	<p>[]</p>

Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: F		
<p>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:</p> <p>A. A service provider shall not restrict or limit a client's rights except:</p> <p>(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or</p> <p>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</p> <p>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</p> <p>B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.</p> <p>C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p>Long Term Services Division Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003 IV. POLICY STATEMENT - Human Rights Committees are required for residential service provider agencies. The purpose of these</p>	<p>Based on record review, the Agency failed to follow DDSD Policy regarding Human Rights Committee Requirements.</p> <p>Review of the Agency Policy & Procedure %Behavior Support Policy+did not address the frequency and purpose of meetings and did not address the review of Behavior Support Plans approved by the Human Rights Committee are to be reviewed at least quarterly.</p> <p>When #52 was asked if their Agency's Policy & Procedure addressed Human Rights. The following was reported:</p> <ul style="list-style-type: none"> • #52 stated %No, but we would meet with the therapist and speak with the Case Manager as well.+ 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <p>]</p>	<p>[]</p>

committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:

- ~ Aversive Intervention Prohibitions
- ~ Psychotropic Medications Use
- ~ Behavioral Support Service Provision.

A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS

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

2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.

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

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

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

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

Tag # 1A32 & 6L14 (CoP) ISP Implementation	Scope and Severity Rating: F		
<p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 4 of 4 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Administrative Files Reviewed:</p> <p>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #2</p> <ul style="list-style-type: none"> • Actions Steps for, %will be able to find the items and purchase them without assistance+was not being completed at the required frequency indicated in the ISP for 5/2011 - 7/2011. <p>Individual #3</p> <ul style="list-style-type: none"> • Actions Steps for, %will wash the family car 1x weekly+was not being completed at the required frequency indicated in the ISP for 04/2011 . 07/2011. <p>Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #4</p> <ul style="list-style-type: none"> • None found regarding: % will decorate my room+for 05/2011 . 07/2011 • None found regarding: % will host three (3) Stanley Product Parties+for 05/2011 . 07/2011 <p>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP</p>	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <p>]</p>	<p>[]</p>

	<p>Outcomes:</p> <p>Individual #1</p> <ul style="list-style-type: none"> • Actions Steps for, % will read at least eight (8) books+was not being completed at the required frequency indicated in the ISP for 04/2011 . 07/2011. <p>Individual #4</p> <ul style="list-style-type: none"> • None found regarding % will go to social activities every other month+for 04/2011 . 07/2011. <p>Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #3</p> <ul style="list-style-type: none"> • Actions Steps for % will learn how to upload and download various media onto his lap top using CDs or flash drives in 1 year+was not being completed at the required frequency indicated in the ISP for 04/2011 - 07/2011. <p>Residential Files Reviewed:</p> <p>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #2</p> <ul style="list-style-type: none"> • % will be able to find the items and purchase them without assistance.+ Outcome was not being completed at required frequency for 8/1 - 8/2011. <p>Individual #3</p> <ul style="list-style-type: none"> • % will wash the family car 1x weekly.+is to be completed 1 times per week. Outcome was not being completed at required frequency for 8/1 - 8/2011. 		
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Tag # 1A36 Service Coordination	Scope and Severity Rating: C		
<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>NMAC 7.26.5.7 service coordinator: the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency</p> <p>NMAC 7.26.5.11 (b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 1 Service Coordinators.</p> <p>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</p> <ul style="list-style-type: none"> • Pre-Service Manual (SC #51) • Person Centered Planning (2-Day) (SC #51) • Promoting Effective Teamwork (SC #51) 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/> <p>]</p>	<p>]]</p>

service coordinators shall assure the action plans and strategies are implemented consistent with the provisions of the ISP, and shall report to the case manager on ISP implementation and the individual's progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more key+ community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDTs selection are set forth as follows:

- (i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;
- (ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;
- (iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;
- (iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;

Tag # 1A37 Individual Specific Training	Scope and Severity Rating: F		
<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>(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>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>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.</p>	<p>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 11 of 12 Agency Personnel.</p> <p>Review of personnel records found no evidence of the following:</p> <p>Direct Service Professional Personnel (DSP):</p> <ul style="list-style-type: none"> Individual Specific Training (#40, 41, 42, 43, 44, 46, 47, 48, 49 & 50) <p>Service Coordination Personnel (SC):</p> <ul style="list-style-type: none"> Individual Specific Training (#51) 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/> <p>]</p>	<p>]]</p>

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: B		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</p> <p>E. Provider Agency Reporting Requirements: All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation:</p> <ol style="list-style-type: none"> (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: <ol style="list-style-type: none"> (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD. 	<p>Based on record review, the Agency failed to complete quarterly reports as required for 2 of 4 individuals receiving Community Inclusion services.</p> <p>Adult Habilitation Quarterly Reports</p> <ul style="list-style-type: none"> • Individual #3 - None found for 10/2010 - 3/2011 • Individual #4 - None found for 10/2010 - 4/2011 <p>Community Access Quarterly Reports</p> <ul style="list-style-type: none"> • Individual #3 - None found for 10/2010 - 03/2011 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/> <p>]</p>	<p>[]</p>

Tag # 5144 AH Reimbursement	Scope and Severity Rating: A	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p>B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ol style="list-style-type: none"> (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XVI. REIMBURSEMENT</p> <p>A. Billable Unit. A billable unit for Adult Habilitation</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 1 of 4 individuals.</p> <p>Individual #4 April 2011</p> <ul style="list-style-type: none"> • The Agency billed 442 units of Adult Habilitation from 04/03/2011 through 04/23/2011. Insufficient documentation found on 4/3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 19, 20, 21, 22 & 23, 2011 to justify billing. <p>May 2011</p> <ul style="list-style-type: none"> • The Agency billed 768 units of Adult Habilitation from 05/01/2011 through 05/31/2011. Documentation received accounted for 560 units. Additionally documentation on 5/21 & 22 did not contain start and end time to justify billing. <p>June 2011</p> <ul style="list-style-type: none"> • The Agency billed 168 units of Adult Habilitation from 06/11/2011 through 06/19/2011. Documentation received accounted for 92 units. Additionally documentation on 06/11, 12, 13, 14 & 19, 2011 did not contain start and end time to justify billing. 	<p>]</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/> <p>]</p>

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

B. Billable Activities

(1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non-face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours.

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

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES</p> <p>A. Support to Individuals in Family Living: The Family Living Services Provider Agency shall provide and document:</p> <p>(5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include:</p> <p>(a) Review, advise, and prompt the implementation of the individual's ISP Action Plans, schedule of activities and appointments; and</p> <p>(b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members.</p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS</p> <p>D. Scope of DDSD Agreement</p>	<p>Based on record review, the Agency failed complete all DDSD requirements for approval of each direct support provider for 1 of 2 individuals.</p> <p>The following was not found, not current and/or incomplete:</p> <ul style="list-style-type: none"> • Family Living (Annual) Home Study <ul style="list-style-type: none"> ◦ Individual #2 - Not Found. 	<p>Provider:</p> <p>In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/>	<p>]]</p>

(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 # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: F	
<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, whichever 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 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</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 3 individuals receiving Community Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Annual Physical (#4) • Dental Exam <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #3 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #4 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • Vision Exam <ul style="list-style-type: none"> ◦ Individual #2 - Per documentation reviewed, the individual wears glasses. No evidence of exam results were found. ◦ Individual #3 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #4 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. 	<p>Provider:</p> <p>In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p>

<p>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> <ul style="list-style-type: none"> (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine). <p>NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.</p> <p>B. Documentation of test results: Results of tests</p>			
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and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

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 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</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 1 of 2 Individuals receiving Family Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Progress Notes/Daily Contacts Logs: <ul style="list-style-type: none"> ◦ Individual #3 - None found for 8/1/2011 . 8/8/2011 • Health Care Providers Written Orders (#3) • Record of visits of healthcare practitioners (#3) • Medication Administration Record (MAR) <ul style="list-style-type: none"> ◦ Individual #3 - None found for 8/1/2011 . 8/8/2011. 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <p>]</p>

<p>a physician or qualified health care provider 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 including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and</p> <p>(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</p>			
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discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.

Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Scope and Severity Rating: C		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>D. Community Living Service Provider Agency Reporting Requirements: All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation:</p> <ol style="list-style-type: none"> (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members. 	<p>Based on record review, the Agency failed to complete written quarterly status reports for 3 of 3 individuals receiving Community Living Services.</p> <p>Family Living Annual Assessment</p> <ul style="list-style-type: none"> • Individual #2 - None found for 07/2010 - 07/2011 • Individual #3 - None found for 04/2010 - 04/2011 <p>Independent Living Quarterly Report:</p> <ul style="list-style-type: none"> • Individual #4 - None found for 06/2010 - 03/2011 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/> <p>]</p>	<p>[]</p>

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: F		
<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 are not limited to, fire, chemical and/or hazardous waste spills, and flooding. 	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 2 of 2 Family Living residences.</p> <p>The following items were not found, not functioning or incomplete:</p> <p>Family Living Requirements:</p> <ul style="list-style-type: none"> • 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 (#2 & 3) • 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 are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#2 & 3) 	<p>[</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <p>]</p>	<p>[]</p>

Tag # 6L27 FL Reimbursement	Scope and Severity Rating: C	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p>B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ol style="list-style-type: none"> (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 2 of 2 individuals.</p> <p>Individual #2 April 2011</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 04/03/2011 through 04/29/2011. Documentation received accounted for 24 units. Additionally documentation on 4/3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 24, 25, 26, 27, 28, & 29 did not contain a signature/authenticated name of the staff providing the service to justify billing. <p>May 2011</p> <ul style="list-style-type: none"> • The Agency billed 28 units of Family Living from 05/01/2011 through 05/28/2011. Documentation received accounted for 24 units. Additionally, documentation on 5/1, 2, 3, 4, 5, 6, 10, 11, 12, 13, 15, 17, 18, 19, 20, 22, 24, 25, 26, & 27 did not contain a signature/authenticated name of the staff providing the service to justify billing. <p>June 2011</p> <ul style="list-style-type: none"> • The Agency billed 14 units of Family Living from 06/12/2011 through 06/25/2011. Documentation received accounted for 2 units. Additionally, documentation on 6/12, 13, 15, 17, 19, 20, 22 & 24 did not contain a signature/authenticated name of the staff providing the service to justify billing. 	<p>]</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <hr/> <p>]</p>

- B. Reimbursement for Family Living Services
- (1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year.
- (2) Billable Activities shall include:
- (a) Direct support provided to an individual in the residence any portion of the day;
 - (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and
 - (c) Any other activities provided in accordance with the Scope of Services.
- (3) Non-Billable Activities shall include:
- (a) The Family Living Services Provider Agency may not bill the for room and board;
 - (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and
 - (c) Family Living services may not be billed for the same time period as Respite.
 - (d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **Chapter 6 - COMMUNITY LIVING SERVICES**

III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES

C. Service Limitations. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore,

a specified deduction to the daily rate for Family Living shall be made for each unit of respite received.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - **DEFINITIONS**
SUBSTITUTE CARE means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider.

RESPITE means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.

Tag # 6L28 IL Reimbursement	Scope and Severity Rating: C	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p>B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <p>(1) Date, start and end time of each service encounter or other billable service interval;</p> <p>(2) A description of what occurred during the encounter or service interval; and</p> <p>(3) The signature or authenticated name of staff providing the service.</p> <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p> <p>Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Independent Living Services for 1 of 1 individual.</p> <p>Individual #4 April 2011</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Independent Living Service from 4/2 . 30, 2011. Documentation on 4/2, 3, 4, 5, 6, 9, 10, 11, 13, 14, 16,18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 did not contain the following: <ul style="list-style-type: none"> ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A description of what occurred during the encounter or service interval to justify billing. ◦ Documentation did not contain start and end time on 4/10, 23, 24, 25, 26, 27, 29 & 30 to justify billing. <p>May 2011</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Independent Living Service from May 1 . 31, 2011. Documentation on 5/1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 & 30 did not contain the following: <ul style="list-style-type: none"> ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A description of what occurred during the encounter or service interval to justify billing. <p>June 2011</p> <ul style="list-style-type: none"> • The Agency billed 1 unit of Independent Living Service from June 1 . 30, 2011. Documentation 	<p>]</p> <p><u>Provider:</u> In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.</p> <p>]</p>

<p>D. Reimbursement for Independent Living Services: The billable unit for Independent Living Services is a monthly rate with a maximum of 12 units a year. Independent Living Services is reimbursed at two levels based on the number of hours of service needed by the individual as specified in the ISP. An individual receiving at least 20 hours but less than 100 hours of direct service per month will be reimbursed at Level II rate. An individual receiving 100 or more hours of direct service per month will be reimbursed at the Level I rate.</p>	<p>on 06/01, 02, 03, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17 20, 21, 22, 23, 24, 26, 27, 28, 29 & 30/2011 did not contain the following:</p> <ul style="list-style-type: none"> ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A description of what occurred during the encounter or service interval to justify billing 		
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Date: November 1, 2011

To: Ms. Lucy Aguilar, Executive Director

Provider: Alternative Personal Care, LLC
Address: 1215 Anthony Drive, Suite A
State/Zip: Anthony, New Mexico 88021

CC (email): Ms. Paulina Aguilar, Alternative Personal Care, LLC

Region: Southwest
Survey Date: August 8 - 10, 2011
Program Surveyed: Developmental Disabilities Waiver
Services Surveyed: Community Living (Independent Living & Family Living) & Community Inclusion (Adult Habilitation & Community Access)
Survey Type: Routine

Dear Ms. Aguilar:

The Division of Health Improvement Quality Management Bureau received the documents you submitted for your Plan of Correction.

Because your Provider Agreement with the Department of Health expired on September 30, 2011 your documents are being forwarded to the Human Services Department for final review.

Thank you for your cooperation with the Plan of Correction process.

Sincerely,

A handwritten signature in black ink that reads "George Perrault". The signature is written in a cursive, flowing style.

George Perrault, MBA
Plan of Correction Coordinator

Cc: DHI
DDSD