

Date: June 7, 2011

To: Edward Kaul, Community Services Director  
Provider: ARCA  
Address: 11300 Lomas Blvd. NE  
State/Zip: Albuquerque, NM 87112

E-mail Address: [ekaul@arc-a.org](mailto:ekaul@arc-a.org)

CC: Diane Fisher, Board Chair  
E-Mail Address: [dfisher@phs.org](mailto:dfisher@phs.org)

Region: Metro  
Survey Date: Month 9 - 12, 2011  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation)

Survey Type: Focused  
Team Leader: Cynthia Nielsen MSN RN ONC CCM, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Crystal Lopez-Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management, Stephanie Martinez de Berenger, MPA, GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Maurice Gonzales, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management, Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management, Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management & Thomas Truby RN, Healthcare Surveyor, Developmental Disabilities Support Division.

Dear Mr. Kaul,

The Division of Health Improvement/Quality Management Bureau has completed a focused compliance survey of the services identified above. The purpose of the focused survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. The specific focus of the survey was to determine compliance with Health Care Services and Nursing Oversight. 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.

**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 working 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**



*"Assuring safety and quality of care in New Mexico's health facilities and community-based programs."*

**Roger Gillespie, Acting Division Director • Division of Health Improvement**

Quality Management Bureau • 5301 Central Ave. NE Suite 400 • Albuquerque, New Mexico 87108  
(505) 222-8623 • FAX: (505) 222-8661 • <http://dhi.health.state.nm.us>

QMB Report of Findings – ARCA – Metro Region – May 9 - 12, 2011

## 2. Developmental Disabilities Supports Division Regional Office for region of service surveyed

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 working days. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as all remedies must still be completed within 45 working 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 working days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

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

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 working 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,

*Cynthia Nielsen MSN RN ONC CCM*

Team Lead/Clinical Liaison  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: May 9, 2011

Present:

**ARCA**

Mahalah Stromquist, Division Director

**DOH/DHI/QMB**

Cynthia Nielsen MSN RN ONC CCM, Team Lead/ Clinical Liaison  
Crystal Lopez-Beck, BA, Healthcare Surveyor  
Stephanie Martinez de Berenger, MPA, GCDF, Healthcare Surveyor  
Maurice Gonzales, BS, Healthcare Surveyor  
Scott Good, MRC, CRC, QMB Deputy Bureau Chief  
Nadine Romero, LBSW, Healthcare Surveyor

**DDSD - Metro Regional Office**

Thomas Truby RN, Regional Office Nurse

Exit Conference Date: May 12, 2011

Present:

**ARCA**

Lauren DeCarlo RN, Nursing Services Manager  
Cecile Evola, Program Manager  
Ashley Garcia, Administrative Coordinator  
Helen Griego, Residential Instructor, Direct Staff  
Sharon Hannah, Case Records Manager  
Edward Kaul, Community Programs Director  
Jennifer Madrid, Family-Based Services Quality Coordinator  
Mahalah Stromquist, Division Director

**DOH/DHI/QMB**

Cynthia Nielsen MSN RN ONC CCM, Team Lead/Clinical Liaison  
Crystal Lopez-Beck, BA, Healthcare Surveyor  
Maurice Gonzales, BS, Healthcare Surveyor  
Nadine Romero, LBSW, Healthcare Surveyor

**DDSD - Metro Regional Office**

Kathleen Linnehan, Metro Regional Office Director (by phone)

Homes Visited	Number:	10
❖ Supported Homes Visited	Number:	7
❖ Family Homes Visited	Number:	3
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	14
		7 - <i>Jackson</i> Class Members
		7 - Non- <i>Jackson</i> Class Members
		11 - Supported Living
		3 - Family Living
		2 - Adult Habilitation
Records Reviewed (Persons Served)	Number:	12 (Administrative)
Residential Files Reviewed	Number:	14 (Residential)

Administrative Files Reviewed

- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure

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](mailto: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;

- 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](mailto: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 "approve" 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.



## **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:** ARCA - Metro Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Living (Supported Living & Family Living) & Community Inclusion (Adult Habilitation)  
**Monitoring Type:** Focused Survey  
**Date of Survey:** May 9 - 12, 2011

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<b>Tag # 1A05 (CoP) General Requirements</b>	<b>Scope and Severity Rating: F</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>A. General Requirements:</b></p> <p>(2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDS policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.</p>	<p>Based on record review, the Agency failed to review and update their written policies and procedures every three years or as needed and failed to develop written policies and procedures that comply with all DDS policies and procedures.</p> <p><b>The following policies and procedures provided during the on-site survey (May 11, 2011) showed no evidence of being reviewed every three years or being updated as needed:</b></p> <ul style="list-style-type: none"> <li>• Policy #2.2-Health Care- Last reviewed and/or revised 10/31/07.</li> <li>• Policy #3.4-Critical Incidents - Last reviewed and/or revised 10/31/07.</li> </ul> <p><b>Review of Agency policies &amp; procedures found no evidence of the following:</b></p> <ul style="list-style-type: none"> <li>• Policy describing Safe Storage of Medication in the Family Living setting.</li> </ul>		

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><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>E. Medication Delivery:</b> 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"> <li>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;</li> <li>Prescribed dosage, frequency and method/route of administration, times and dates of administration;</li> <li>Initials of the individual administering or assisting with the medication;</li> <li>Explanation of any medication irregularity;</li> <li>Documentation of any allergic reaction or adverse medication effect; and</li> </ol>	<p>Medication Administration Records (MAR) were reviewed for the months of January, February, March &amp; May 2011.</p> <p>Based on record review, 9 of 14 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #2 January 2011 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>Nifedipine 30mg (1 time daily)</li> <li>Fluticasone 50mcg (1 time daily)</li> <li>Albuterol 0.85% 1 unit (2 times daily)</li> </ul> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> <li>Albuterol 0.85% 1 unit (1 time daily)</li> </ul> <p>February 2011 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>Albuterol 0.85% 1 unit (2 times daily)</li> <li>Baclofen 20mg (3 times daily)</li> <li>Ciprofloxin 250mg (every 12 hours for 3 days)</li> <li>Fluticasone 50mcg (1 time daily)</li> <li>Nifedipine 30mg (1 time daily)</li> </ul> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> <li>Albuterol 0.85% 1 unit (2 times daily)</li> </ul> <p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</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><b>NMAC 16.19.11.8 MINIMUM STANDARDS:</b>  <b>A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</b></p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, <b>including over-the-counter medications</b>. This documentation shall include:</p> <ul style="list-style-type: none"> <li>(i) Name of resident;</li> <li>(ii) Date given;</li> <li>(iii) Drug product name;</li> <li>(iv) Dosage and form;</li> <li>(v) Strength of drug;</li> <li>(vi) Route of administration;</li> <li>(vii) How often medication is to be taken;</li> <li>(viii) Time taken and staff initials;</li> <li>(ix) Dates when the medication is discontinued or changed;</li> <li>(x) The name and initials of all staff</li> </ul>	<ul style="list-style-type: none"> <li>• Multivitamin (1 time daily) – Blank 2/25 &amp; 26 (8:00 AM)</li> </ul> <p>March 2011  Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Albuterol 0.85% 1 unit (2 times daily)</li> <li>• Fluticasone 50mcg (1 time daily)</li> </ul> <p>Individual #3  February 2011  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Chlorhexidine dental rinse (2 times daily) – Blank 2/2 &amp; 27 (8:00 AM)</li> </ul> <p>March 2011  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Chlorhexidine dental rinse (2 times daily) – Blank 3/25 (8:00 AM)</li> </ul> <p>Individual #4  March 2011  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Baclofen 10mg (3 times daily) – Blank 3/4 (8:00 AM)</li> </ul> <p>Individual #5  February 2011  Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Zithromax 200mg/5ml (1 time daily)</li> <li>• Azithromycin 2 tsp (1 time daily)</li> </ul> <p>March 2011</p>	
--	---	--

<p>administering medications.</p> <p><b>Model Custodial Procedure Manual</b>  <b>D. Administration of Drugs</b>  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"> <li>➤ symptoms that indicate the use of the medication,</li> <li>➤ exact dosage to be used, and</li> <li>➤ the exact amount to be used in a 24 hour period.</li> </ul>	<p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Azithromycin 2 tsp (1 time daily)</li> </ul> <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> <li>• Azithromycin (1 time daily)</li> </ul> <p>May 2011  Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> <li>• Tegretol (2 times daily)</li> </ul> <p>Individual #6  January 2011  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Nystatin suspension (4 times daily) – Blank 1/16 (6:00am)</li> <li>• Nystatin suspension (4 times daily) – Blank 1/14 (4:00pm)</li> <li>• Nystatin suspension (4 times daily) – Blank 1/16 (6:00pm)</li> <li>• Trazadone 50mg (1 time daily) – Blank 1/16 (7:00pm)</li> </ul> <p>Individual #8  January 2011  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Zonisamide 100mg (1 time daily) – Blank 1/31 (9:00 PM)</li> </ul> <p>February 2011  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p>		
---	--	--	--

	<ul style="list-style-type: none"> <li>• Zonisamide 100mg (1 time daily) – Blank 2/28 (9:00 PM)</li> </ul> <p>Individual # 9 February 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Risperidone 0.25mg (2 times daily) – Blank 2/24 (7:00 AM)</li> </ul> <p>Individual #10 January 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Zegerid (1 time daily)</li> <li>• Tums (1 time daily)</li> <li>• Avelox (1 time daily)</li> <li>• Fluticasone nasal spray (1 time daily)</li> <li>• Phenobarbital 5ml (3 times daily)</li> </ul> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> <li>• Tums (1 time daily)</li> <li>• Multivitamin (1 time daily)</li> </ul> <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> <li>• Zegerid (1 time daily)</li> <li>• Tums (1 times daily)</li> <li>• Avelox (1 time daily)</li> <li>• Phenobarbital 5ml (3 times daily)</li> <li>• Valproic Acid 9ml (3 times daily)</li> </ul> <p>February 2010 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p>		
--	--	--	--

	<ul style="list-style-type: none"> <li>• Zegerid (1 time daily)</li> <li>• Tums (1 time daily)</li> <li>• Fluticasone nasal spray (1 time daily)</li> </ul> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> <li>• Tums (1 time daily)</li> <li>• Multivitamin (1 time daily)</li> <li>• Zegerid (1 time daily)</li> </ul> <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> <li>• Zegerid (1 time daily)</li> <li>• Tums (1 times daily)</li> <li>• Phenobarbital 5ml (3 times daily)</li> <li>• Valproic Acid 9ml (3 times daily)</li> </ul> <p>March 2011</p> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Zegerid (1 time daily)</li> <li>• Tums (1 time daily)</li> <li>• Avelox (1 time daily)</li> <li>• Fluticasone nasal spray (1 time daily)</li> <li>• Phenobarbital 5ml (3 times daily)</li> </ul> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> <li>• Tums (1 time daily)</li> <li>• Multivitamin (1 time daily)</li> </ul> <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> <li>• Zegerid (1 time daily)</li> <li>• Calcium</li> <li>• Avelox (1 time daily)</li> </ul>		
--	--	--	--

	<ul style="list-style-type: none"> <li>• Phenobarbital 5ml (3 times daily)</li> <li>• Valproic Acid 9ml (3 times daily)</li> </ul> <p>May 2011 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records:</p> <ul style="list-style-type: none"> <li>• Zegerid (1 time daily)</li> </ul> <p>Individual #11 January 2011 Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> <li>• Calcium</li> </ul> <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> <li>• Calcium</li> </ul> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> <li>• Carbamazepine 400mg (3 times daily)</li> <li>• Baclofen 20mg (4 times daily)</li> <li>• Multivitamin (1 time daily)</li> <li>• Calcium</li> </ul> <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> <li>• Calcium</li> </ul> <p>February 2011 Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> <li>• Calcium</li> </ul> <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> <li>• Calcium</li> </ul>		
--	--	--	--



	<p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> <li>• Carbamazepine 400mg (3 times daily)</li> <li>• Baclofen 20mg (4 times daily)</li> <li>• Multivitamin (1 time daily)</li> <li>• Calcium</li> </ul> <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> <li>• Calcium</li> </ul> <p>March 2011</p> <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> <li>• Calcium</li> </ul> <p>Medication Administration Records did not contain the frequency of medication to be given:</p> <ul style="list-style-type: none"> <li>• Calcium</li> </ul> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> <li>• Carbamazepine 400mg (3 times daily)</li> <li>• Baclofen 20mg (4 times daily)</li> <li>• Multivitamin (1 time daily)</li> <li>• Calcium</li> </ul> <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> <li>• Calcium</li> </ul>		
--	--	--	--

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><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>E. Medication Delivery:</b> 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"> <li>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;</li> <li>Prescribed dosage, frequency and method/route of administration, times and dates of administration;</li> <li>Initials of the individual administering or assisting with the medication;</li> <li>Explanation of any medication irregularity;</li> <li>Documentation of any allergic reaction or adverse medication effect; and</li> </ol>	<p>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 9 of 14 Individuals.</p> <p>Individual #4 January 2011</p> <p>No evidence of documented Signs/Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> <li>Acetaminophen 160mg/5ml – PRN –1/28 (given 1 time)</li> </ul> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>Acetaminophen 160mg/5ml – PRN –1/28 (given 1 time)</li> </ul> <p>March 2011</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>Acetaminophen 500mg/15ml – PRN –3/13 (given 1 time)</li> <li>Immodium AD 2mg – PRN – 3/8 &amp; 9 (given 3 times)</li> </ul> <p>Individual #5 February 2011</p> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> <li>Acetaminophen 160mg/5ml</li> </ul> <p>As indicated by the controlled drug record, the individual took the following medication. Review of the Medication Administration Record found no evidence that medication is documented on the MAR.</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><b>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</b></p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, <b>including over-the-counter medications</b>. This documentation shall include:</p> <ul style="list-style-type: none"> <li>(i) Name of resident;</li> <li>(ii) Date given;</li> <li>(iii) Drug product name;</li> <li>(iv) Dosage and form;</li> <li>(v) Strength of drug;</li> <li>(vi) Route of administration;</li> <li>(vii) How often medication is to be taken;</li> <li>(viii) Time taken and staff initials;</li> <li>(ix) Dates when the medication is discontinued</li> </ul>	<ul style="list-style-type: none"> <li>• Lorazepam 1mg- 2/7 at 10:30am</li> </ul> <p>Individual #6 March 2011 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Acetaminophen 500mg – PRN –3/2 (given 1 time)</li> </ul> <p>Individual #7 January 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Guaifensin 100mg – PRN –1/11 &amp; 1/20 (given 1 time)</li> </ul> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Guaifensin 100mg – PRN –1/11 &amp; 1/20 (given 1 time)</li> </ul> <p>February 2011 No evidence of documented Signs/Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Guaifensin 100mg – PRN –2/15 (given 1 time)</li> </ul> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Guaifensin 100mg – PRN –2/15 (given 2 times)</li> </ul> <p>Individual #8 January 2011 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Fexofenadine 180mg – PRN –1/22 (given 1 time)</li> </ul> <p>Individual #9</p>		
--	--	--	--

<p>or changed;</p> <p>(x) The name and initials of all staff administering medications.</p> <p><b>Model Custodial Procedure Manual</b>  <b>D. Administration of Drugs</b>  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"> <li>➤ symptoms that indicate the use of the medication,</li> <li>➤ exact dosage to be used, and</li> <li>➤ the exact amount to be used in a 24 hour period.</li> </ul> <p><b>Department of Health</b>  <b>Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006</b>  <b>F. PRN Medication</b>  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.</p>	<p>January 2011</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Acetaminophen 500mg – PRN –1/6, 7, 8, 22 &amp; 24 (given 1 time) &amp; 1/21 (given 3 times)</li> <li>• Ibuprofen 200mg – PRN – 1/20 (given 1 time)</li> <li>• Robitussin DM Syrup 2 tsp – PRN – 1/26 (given 1 time)</li> <li>• Sudafed PE 10mg – PRN – 1/25 (given 1 time)</li> </ul> <p>February 2011</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Acetaminophen 500mg – PRN –1/22 (given 2 times)</li> </ul> <p>As indicated by the controlled drug record, the individual took the following medication. Review of the Medication Administration Record found no evidence that medication is documented on the MAR.</p> <ul style="list-style-type: none"> <li>• Lorazepam 2mg- 3/10 at 11:30am</li> </ul> <p>March 2011</p> <p>No evidence of documented Signs/Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Pepto Bismol Suspension – PRN – 3/8 (given 1 time)</li> </ul> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Acetaminophen 500mg – PRN –3/1, 7 &amp; 19 (given 1 times)</li> <li>• Pepto Bismol Suspension – PRN – 3/8 (given 1</li> </ul>		
---	---	--	--

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.

time)

Individual #10  
January 2011

Medication Administration Records did not contain the strength of the medication which is to be given:

- Albuterol Sulfate (PRN)

Medication Administration Records did not contain the circumstance for which the medication is to be used:

- Albuterol Sulfate (PRN)

Medication Administration Records did not contain the route of administration for the following medications:

- Albuterol Sulfate (PRN)

Individual #11  
January 2011

Medication Administration Records did not contain the route of administration for the following medications:

- Aleve (PRN)

Medication Administration Records did not contain the exact amount to be used in a 24 hour period:

- Aleve (PRN)

No evidence of documented Signs/Symptoms were found for the following PRN medication:

- Aleve 225mg – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 & 15 (given 2 times)

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:

- Aleve 225mg – PRN – 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 & 15 (given 2 times)

<p>(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).</p> <p>a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.</p> <p>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.).</p>	<p>February 2011</p> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> <li>• Aleve (PRN)</li> </ul> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> <li>• Aleve (PRN)</li> </ul> <p>No evidence of documented Signs/Symptoms were found for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Dulcolax Suppository – PRN – 2/23 &amp; 28 (given 1 time)</li> <li>• Aleve 225mg – PRN – 2/14 (given 1 time) &amp; 2/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 &amp; 28 (given 2 times)</li> </ul> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Dulcolax Suppository – PRN – 2/23 &amp; 28 (given 1 time)</li> <li>• Aleve 225mg – PRN – 2/14 (given 1 time) &amp; 2/15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 &amp; 28 (given 2 times)</li> </ul> <p>March 2011</p> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> <li>• Aleve (PRN)</li> </ul> <p>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> <li>• Aleve (PRN)</li> </ul> <p>No evidence of documented Signs/Symptoms</p>		
---	---	--	--

	<p>were found for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Dulcolax Suppository – PRN – 3/3, 7, 10, 12, 14, 17, 20, 23, 26 &amp; 30 (given 1 time)</li> <li>• Aleve 220mg – PRN – 3/1 (given 2 times) &amp; 3/2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 &amp; 18 (given 1 time)</li> </ul> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Dulcolax Suppository – PRN – 3/3, 7, 10, 12, 14, 17, 20, 23, 26 &amp; 30 (given 1 time)</li> <li>• Aleve 220mg – PRN – 3/1 (given 2 times) &amp; 3/2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 &amp; 18 (given 1 time)</li> </ul> <p>Individual #12 March 2011</p> <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> <li>• Sudafed PE 10mg – PRN – 3/19 &amp; 21 (given 2 times) &amp; 3/22 (given 1 time)</li> </ul>		
--	--	--	--

Tag # 1A15.1 Nurse Availability	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007  <b>Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:</b> 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><b>NEW MEXICO NURSING PRACTICE ACT CHAPTER 61, ARTICLE 3</b></p> <p>I. "licensed practical nursing" means the practice of a directed scope of nursing requiring basic knowledge of the biological, physical, social and behavioral sciences and nursing procedures, which practice is at the direction of a registered nurse, physician or dentist licensed to practice in this state. This practice includes but is not limited to:</p> <p>(1) contributing to the assessment of the health status of individuals, families and communities;  (2) participating in the development and modification of the plan of care;  (3) implementing appropriate aspects of the plan of care commensurate with education and verified competence;  (4) collaborating with other health care professionals in the management of health care; and  (5) participating in the evaluation of responses to interventions;</p>	<p>Based on interview, observation and record review, the Agency failed to ensure nursing services were available as needed for 2 of 14 individuals.</p> <p><b>During record review and Surveyor observation the following occurred:</b></p> <ul style="list-style-type: none"> <li>• During the home visit of Individual #8 on 5/9/11, the nurse assigned to the house was called by #114 at 5:03pm. The agency on-call Nurse did not respond until 6:09pm. According to an interview with #41, the required call back time is 15 - 30 minutes.</li> <li>• According to an interview with #73, Individual #4 was released from Presbyterian Hospital on 4/20/11 with orders for Home Health Care. On 4/22/11 and 5/2/11 Home care visited. Nursing was notified of the discharge and did not visit until after 5/2/11.</li> </ul> <p><b>When Direct Service Professionals (DSP) were asked about the availability of their agency nurse, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #114 stated, "Sometimes she doesn't come out here when we call her. "</li> <li>• DSP #53 stated, "The nurse takes a while to get back to staff."</li> </ul>		



Tag # 1A15.2 & 5109 - Healthcare Documentation	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>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:</b> 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><b>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</b></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"> <li>(i) Community living services provider agency;</li> <li>(ii) Private duty nursing provider agency;</li> <li>(iii) Adult habilitation provider agency;</li> <li>(iv) Community access provider agency; and</li> <li>(v) Supported employment provider agency.</li> </ul> <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 complete written medical emergency response plans in compliance with standards for 3 of 12 individuals receiving Community Living Services.</p> <p>Review of Medical Emergency Response Plans for Individuals #1, 5 &amp; 9 found the following components were not addressed as required by the DDS Medical Emergency Response Plans Policy effective 8/1/10:</p> <ul style="list-style-type: none"> <li>(3) A concise list of the most important measures that might prevent the life threatening complications that might occur and what those complications may look like to an observer.</li> <li>(6) Reference to whether the individual has advanced directives or not, and if so, where the advance directives are located.</li> </ul>		

<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 DDS 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><b>(2) Health related plans</b></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>			
--	--	--	--

<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>			
--	--	--	--

<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><b>(4) General Nursing Documentation</b></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><b>Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency</b></p>			
--	--	--	--

**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 directives or not, and if so, where the advance directives are located.

Tag # 1A22 Staff Competence	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</b></p> <p><b>PERSONNEL:</b> 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><b>F. Qualifications for Direct Service Personnel:</b> The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</p> <p>(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;</p> <p>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</p> <p>(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;</p> <p>(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy</p>	<p>Based on interview, the Agency failed to ensure that training competencies were met for 3 of 12 Direct Service Personnel.</p> <p><b>When DSP were asked if they received training on the Individual's Positive Behavioral Supports Plan and what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>DSP #114 stated, "I really don't remember if she has that plan." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #8)</li> </ul> <p><b>When DSP were asked if they received training on the Individual's Speech Therapy Plan and what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>DSP #114 stated, "I'm sure it covers things with communication but I've never had any issues" According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #8)</li> </ul> <p><b>When DSP were asked if they received training on the Individual's Occupational Therapy Plan and what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>DSP #114 stated, "Got training but it's been a long time." During the interview the DSP attempted to look through the books but was unable to find the plan. According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #8)</li> <li>DSP #121 stated, "I'm sure there are things we are supposed to do but I don't remember."</li> </ul>		

<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><b>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:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p>	<p>According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #2)</p> <p><b>When DSP were asked if they received training on the Individual's Health Care Plans and what the plan(s) covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #53 stated, "Don't know from the top of my head." As indicated by the Agency file, the Individual has a Health Care Plan for Seizures. (Individual #8)</li> <li>• DSP #114 did not answer. During the interview the DSP looked through the books but did not answer the question. As indicated by the Agency file, the Individual has a Health Care Plan for seizures. (Individual #8)</li> </ul> <p><b>When DSP were asked if they received training on the Individual's Crisis Plans/Medical Emergency Response Plans and what the plan covered, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #53 stated, "Not sure on those." As indicated by the Agency file, the Individual has Crisis Plans for skeletal alteration, injury, constipation/impaction, seizure and oral hygiene. (Individual #8)</li> <li>• DSP #121 stated, "No, we didn't get training." As indicated by the Agency file, the Individual has Crisis Plans for seizure disorder, high blood pressure, constipation, airway obstruction/respiratory, anaphylaxis and aspiration (Individual #2)</li> </ul> <p><b>When DSP were asked if they had received training regarding the individual's Seizure Disorder, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #121 stated, "Didn't receive any." When</li> </ul>		
---	---	--	--

asked if a seizure log was kept or available, DSP#121 stated, "No." According to the ISP, the individual has a diagnosis of Seizures. (Individual #2)

**When DSP were asked how many days without a bowel movement would warrant a call to the Agency nurse, the following was reported:**

- DSP #114 referred to #8's Constipation Crisis plan and stated, "It doesn't really give you a time of when to call the nurse." According to the ISP the individual has a diagnosis of Constipation. (Individual #8)



Tag # 1A33.1 Board of Pharmacy - Lic	Scope and Severity Rating: A		
<p><b>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</b></p> <p><b>6. Display of License and Inspection Reports</b></p> <p>A. The following are required to be publicly displayed:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Current Custodial Drug Permit from the NM Board of Pharmacy</li> <li><input type="checkbox"/> Current registration from the consultant pharmacist</li> <li><input type="checkbox"/> Current NM Board of Pharmacy Inspection Report</li> </ul>	<p>Based on observation, the Agency failed to provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 1 of 7 residences:</p> <p>Individual Residence:</p> <ul style="list-style-type: none"> <li>• Current Registration of Consulting Pharmacist (#9)</li> </ul>		

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</b></p> <p><b>G. Health Care Requirements for Community Living Services.</b></p> <p>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first.</p> <p>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</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 1 of 12 individuals receiving Community Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• <b>Vision Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #1 - As indicated by the documentation reviewed, exam was completed on 3/13/2009. Follow-up was to be completed in 2 years. No evidence of follow-up found.</li> </ul> </li> </ul>		

<p>b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <ul style="list-style-type: none"> <li>(a) The individual has a primary licensed physician;</li> <li>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</li> <li>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</li> <li>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</li> <li>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</li> </ul>			
--	--	--	--

Tag # 6L14 Residential Case File	Scope and Severity Rating: F	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>A. Residence Case File:</b> 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 13 of 14 Individuals receiving Family Living Services or Supported Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• <b>Current Emergency &amp; Personal Identification Information</b> <ul style="list-style-type: none"> <li>◦ Did not contain Pharmacy Information (#1 &amp; 11)</li> </ul> </li> <li>• Annual ISP (#9)</li> <li>• Individual Specific Training Section of ISP (formerly Addendum B) (#1 &amp; 9)</li> <li>• Positive Behavioral Plan (#1 &amp; 9)</li> <li>• Positive Behavioral Crisis Plan (#1, 4 &amp; 9)</li> <li>• Speech Therapy Plan (#2, 4, 6, 11, 12, 13 &amp; 14)</li> <li>• Occupational Therapy Plan (#9 &amp; 13)</li> <li>• Physical Therapy Plan (#1, 4, 5, 9, 11 &amp; 13)</li> <li>• <b>Special Health Care Needs</b> <ul style="list-style-type: none"> <li>◦ Meal Time Plan (#11)</li> </ul> </li> <li>• <b>Health Care Plans</b> <ul style="list-style-type: none"> <li>◦ Aspiration (#1, 2, 4, 7 &amp; 11)</li> <li>◦ Aspiration CARMP not signed (#3 )</li> <li>◦ Health Care Plan per IST section of ISP (#1)</li> <li>◦ Seizures (#1 &amp; #11)</li> <li>◦ Shunt/Neurological Device (#11)</li> </ul> </li> </ul>	

<p>a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> <li>(a) The name of the individual;</li> <li>(b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;</li> <li>(c) Diagnosis for which the medication is prescribed;</li> <li>(d) Dosage, frequency and method/route of delivery;</li> <li>(e) Times and dates of delivery;</li> <li>(f) Initials of person administering or assisting with medication; and</li> <li>(g) An explanation of any medication irregularity, allergic reaction or adverse effect.</li> <li>(h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> <li>(i) Observable signs/symptoms or circumstances in which the medication is to be used, and</li> <li>(ii) Documentation of the effectiveness/result of the PRN delivered.</li> </ul> </li> <li>(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.</li> </ul> <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>	<ul style="list-style-type: none"> <li>◦ Skin Integrity (#11)</li> <li>• <b>Crisis Plans/Medical Emergency Response Plans</b> <ul style="list-style-type: none"> <li>◦ Allergies (#9)</li> <li>◦ Aspiration (#1 &amp; 10)</li> <li>◦ Gastrostomy tube (#7)</li> <li>◦ Oral Hygiene (#11)</li> <li>◦ Seizures (#1, 11 &amp; 13)</li> </ul> </li> </ul>		
--	---	--	--

discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>L. Residence Requirements for Family Living Services and Supported Living Services</b></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"> <li>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</li> <li>(b) General-purpose first aid kit;</li> <li>(c) When applicable due to an individual's health status, a blood borne pathogens kit;</li> <li>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;</li> <li>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;</li> <li>(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;</li> <li>(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</li> <li>(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.</li> </ul>	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 4 of 10 Supported Living &amp; Family Living residences.</p> <p>The following items were not found, not functioning or incomplete:</p> <p><b>Supported Living Requirements:</b></p> <ul style="list-style-type: none"> <li>• Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#9)</li> <li>• 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 (#9 &amp; 12)</li> </ul> <p><b>Family Living Requirements:</b></p> <ul style="list-style-type: none"> <li>• Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#10 &amp; 11)</li> <li>• 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 (#10 &amp; 11)</li> </ul>		