Date: August 31, 2011

To: Isaac Sandoval, Executive Director/Owner
Provider: At Home Advocacy
Address: 3701 San Mateo Blvd. NE Ste. 200
State/Zip: Albuquerque, New Mexico 87110

E-mail Address: athomenm@gmail.com

Region: Metro
Original Survey Date: November 30 - December 3, 2010
Verification Date: August 9 – 11, 2011
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Family Living) & Community Inclusion (Community Access)
Survey Type: Verification
Team Leader: Crystal Lopez-Beck, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Maurice Gonzales, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Sandoval;

The Division of Health Improvement/Quality Management Bureau has completed a verification survey of the services identified above. The purpose of the survey was to determine compliance with you Plan of Correction submitted to DHI/DDSD regarding the Routine Survey on ***November 30 – December 3, 2010.***

These findings will be reviewed by the DOH – Internal Review Committee during an upcoming review meeting. The findings are attached. You will be contacted by the Department for further instructions regarding your plan of correction requirements.

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

Sincerely,

Crystal Lopez-Beck, BA

Crystal Lopez-Beck, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	August 9, 2011
Present:	**At Home Advocacy** Jessica Gutierrez, Service Coordinator Ben Velarde, RN **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor Maurice Gonzales, BS, Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor
Exit Conference Date:	August 11, 2011
Present:	**At Home Advocacy** Ben Velarde, RN Jeanne Saavedra, Services Coordinator **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Team Lead/Healthcare Surveyor Maurice Gonzales, BS, Healthcare Surveyor
Total Homes Visited	Number: 6
❖ Family Homes Visited	Number: 6
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 8 1 - *Jackson* Class Members 7 - Non-*Jackson* Class Members 7 - Family Living 2 - Community Access
Person Served Records Reviewed	Number: 8
Direct Service Professionals Record Review	Number: 55
Service Coordinator Record Review	Number 5
Administrative Files Reviewed	• Billing Records • Medical Records • Personnel Files • Training Records • Agency Policy and Procedure • Caregiver Criminal History Screening Records • Employee Abuse Registry • Quality Assurance / Improvement Plan

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

Attachment B

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.

Attachment C

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

Introduction:
Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means 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 DDSD provider contract.

A Provider forfeits the right to an IRF if the request is not made within 10 working days of receiving the report and/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: **At Home Advocacy - Metro Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Family Living) & Community Inclusion (Community Access)
Monitoring Type: Verification Survey
Original Survey Date: **November 30 - December 3, 2010**
Verification Date: **August 9 – 11, 2011**

Standard of Care	November 30 - December 3, 2010 Deficiencies	August 9 - 11, 2011 Verification Survey – New and Repeat Deficiencies
Tag # 1A09 Medication Delivery (MAR) - Routine Medication	**Scope and Severity Rating: E**	**Scope and Severity: D**
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care	Medication Administration Records (MAR) were reviewed for the months of August, September & October 2010. Based on record review, 7 of 9 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #2 August 2010 Medication Administration Records indicated medication was to be given 2 times. Medication only signed for once for both time slots. • Colace 50 mg (2 times daily) September 2010 Medication Administration Records indicated medication was to be given 2 times daily at 9am and 5 pm. Medication only signed for once for both time slots. • Colace 50 mg (2 times daily) Individual #3 August 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Trazadone 100mg (1 time daily) – Blank 8/1, 12,	**New & Repeat Findings:** Medication Administration Records (MAR) were reviewed for the months of April, May & June 2011. Based on record review, 1 of 7 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #8 Medication Administration Records indicate the individual is to take Ranitidine 300mg (2 times daily). According to the Physician's Orders, Ranitidine 300mg is to be taken 1 time daily. Medication Administration Record & Physician's Orders do not match. Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Aspirin 80mg (1 time daily)

provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This	13, 14 & 15 (7 PM) • Fiber Laxative 625mg (1 time daily) - Blank 8/1, 12, 13, 14 & 15 (7 PM) • Polyethyiene Glycol 17mg (1 time daily) - Blank 8/12, 13, 14, 15 & 16 (7 AM) • Divalproex 250mg (1 time daily) - Blank 8/13, 14, 15 & 16 (7 AM) • Divalproex 50mg (1 time daily) - Blank 8/13, 14, 15 & 16 (7 AM) • Calcium with Vitamin D 600mg (2 times daily) - Blank 8/13, 14, 15 & 16 (7 AM) & 8/12, 13, 14 & 15 (7 PM) • Divalproex 1000mg (1 time daily) - Blank 8/13, 14 & 15 (7 PM) • Thioridazine 100mg (1 time daily) - Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 & 15 (PM) • Ferrous Sulfate 325mg (1 time daily) - Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 & 18 (7 PM) • Nitrofurantoin 100mg (4 times daily) - Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 & 18 (1st dose); 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 23, 24, 25, 26, 27 & 30 (2nd dose) & 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 19 & 25 (3rd and 4th doses) Medication Administration Record did not contain the time the medication should be given. MAR indicated time as "AM, PM and/or Bedtime": • Thioridazine 100mg (1 time daily)	

documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period.	Medication Administration Record did not contain the time the medication should be given. • Nitrofurantoin 100mg (4 times daily) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Ferrous Sulfate 325mg (1 time daily) • Nitrofurantoin 100mg (4 times daily) September 2010 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Fiber Laxative 625mg (1 time daily) – Blank 09/14 (7 PM) • Nitrofurantoin - Blank 9/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 & 16 (7AM) Medication Administration Records did not contain the dosage for the following medications: • Nitrofurantoin Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Nitrofurantoin Medication Administration Records did not contain the route of administration for the following medications: • Nitrofurantoin Medication Administration Records did not contain the frequency of medication to be given: • Nitrofurantoin October 2010 Medication Administration Records did not contain the diagnosis for which the medication is	

	prescribed: • Ferrous Sulfate 325mg (1 time daily) • Nitrofurantoin 50mg (1 time daily) • Thioridozine 100mg (1 time daily) Medication Administration Records did not contain the route of administration for the following medications: • Ferrous Sulfate 325 mg (1 time daily) • Nitrofurantoin 50mg (1 time daily) • Thioridozine 100mg (1 time daily) Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Calcium with Vitamin D 600mg (2 times daily) – Blank 10/28 (7 PM) Individual #4 August2010 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Ranitidine 5mg (2 times daily) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Famotione (1 time daily) Medication Administration Records did not contain the dosage for the following medications: • Famotione Medication Administration Records did not contain the strength of the medication which is to be given:	

	• Trizine (Cetirizine) 2 tsp (1 time daily) Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Carafate 5mls (4 time daily) – Blank 8/30 & 31 (7:30 AM) September 2010 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Ranitidine 5mg (2 times daily) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Famotione (1 time daily) Medication Administration Records did not contain the dosage for the following medications: • Famotione Medication Administration Records did not contain the strength of the medication which is to be given: • Trizine (Cetirizine) 2tsp (1 time daily) October 2010 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Ranitidine 5mg (2 times daily) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Famotione (1 time daily) Medication Administration Records did not contain	

	the dosage for the following medications: • Famotione Medication Administration Records did not contain the strength of the medication which is to be given: • Trizine (Cetirizine) 2tsp (1 time daily) Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Carafate 5mls (4 times daily) – Blank 10/28, 29 & 31 (8:30 PM) Individual #6 August 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Seroquel 100mg (1 time daily) September 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Seroquel 100mg (1 time daily) October 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Seroquel 100mg (1 time daily) Individual #8 August 2010 Medication Administration Records did not contain the dosage for the following medications: • Glucosamine Sulfate • Calcium • Cranberry Capsules	

	• Fish Oil or Flaxseed • Multivitamin • Ginko Biloba • Vitamin D • Vitamin C • Vitamin E • Magnesium • Vitamin B Complex Medication Administration Records did not contain the frequency of medication to be given: • Glucosamine Sulfate • Calcium • Cranberry Capsules • Fish Oil or Flaxseed • Multivitamin • Ginko Biloba • Vitamin D • Vitamin C • Vitamin E • Magnesium • Vitamin B Complex	

	Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Glucosamine Sulfate • Calcium • Cranberry Capsules • Fish Oil or Flaxseed • Multivitamin • Ginko Biloba • Vitamin D • Vitamin C • Vitamin E • Magnesium • Vitamin B Complex Medication Administration Records did not contain the route of administration for the following medications: • Glucosamine Sulfate • Calcium • Cranberry Capsules • Fish Oil or Flaxseed • Multivitamin • Ginko Biloba • Vitamin D	

	• Vitamin C • Vitamin E • Magnesium • Vitamin B Complex September 2010 Medication Administration Records did not contain the dosage for the following medications: • Glucosamine Sulfate • Calcium • Cranberry Capsules • Fish Oil or Flaxseed • Multivitamin • Ginko Biloba • Vitamin D • Vitamin C • Vitamin E • Magnesium Medication Administration Records did not contain the frequency of medication to be given: • Glucosamine Sulfate • Calcium • Cranberry Capsules • Fish Oil or Flaxseed	

	• Multivitamin • Ginko Biloba • Vitamin D • Vitamin C • Vitamin E • Magnesium Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Glucosamine Sulfate • Calcium • Cranberry Capsules • Fish Oil or Flaxseed • Multivitamin • Ginko Biloba • Vitamin D • Vitamin C • Vitamin E • Magnesium Medication Administration Records did not contain the route of administration for the following medications: • Glucosamine Sulfate	

	• Calcium • Cranberry Capsules • Fish Oil or Flaxseed • Multivitamin • Ginko Biloba • Vitamin D • Vitamin C • Vitamin E • Magnesium As indicated by the Medication Administration Records the individual is to take Levothyroxine 88 mcg (1 time daily). According to the Physician's Orders, Levothyroxine .088 mg is to be taken 1 time daily. Medication Administration Record & Physician's Orders do not match. As indicated by the Physician's Orders the individual is to take the following medication. Review of the Medication Administration Record found no evidence that medication is documented on the MAR. • Vitamin B Complex OTC (1 time daily) October 2010 Medication Administration Records did not contain the dosage for the following medications: • Glucosamine Sulfate • Calcium • Cranberry Capsules • Fish Oil or Flaxseed	

	• Multivitamin • Ginko Biloba • Vitamin D • Vitamin C • Vitamin E • Magnesium • Vitamin B Complex Medication Administration Records did not contain the frequency of medication to be given: • Glucosamine Sulfate • Calcium • Cranberry Capsules • Fish Oil or Flaxseed • Multivitamin • Ginko Biloba • Vitamin D • Vitamin C • Vitamin E • Magnesium • Vitamin B Complex Medication Administration Records did not contain the diagnosis for which the medication is	

	prescribed: • Glucosamine Sulfate • Calcium • Cranberry Capsules • Fish Oil or Flaxseed • Multivitamin • Ginko Biloba • Vitamin D • Vitamin C • Vitamin E • Magnesium • Vitamin B Complex Medication Administration Records did not contain the route of administration for the following medications: • Glucosamine Sulfate • Calcium • Cranberry Capsules • Fish Oil or Flaxseed • Multivitamin • Ginko Biloba • Vitamin D • Vitamin C	

	• Vitamin E • Magnesium • Vitamin B Complex Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Vitamin D – Blank 10/27, 28 & 29 (8 AM) • Ranitidine 300mg (2 times daily) - Blank 10/1, 2 & 3 (6 PM) As indicated by the Medication Administration Records the individual is to take Levothyroxine .088 **mcg** (1 time daily). According to the Physician's Orders, Levothyroxine .088 **mg** is to be taken 1 time daily. Medication Administration Record & Physician's Orders do not match. Individual #9 August 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Piroxicam 20mg (1 time daily) September 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Piroxicam 20mg (1 time daily) October 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Piroxicam 20mg (1 time daily) • Abilify 10mg (1 time daily)	

	• Iron 65mg (1 time daily) • Cephalexin 500mg (3 times daily) Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Zoloft 50mg (1 time daily) • Risperidal 4mg (1 time daily) • Prilosec OTC (2 times daily) Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Piroxicam 20mg (1 time daily) – Blank 10/30 (8:30 AM) • Cephalexin 500mg (3 times daily) - Blank 10/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 & 20 (8:30AM, 2PM & 6PM) Individual #10 October 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Amoxicillin/Clavulanate 400mg/5 (2 times daily)	

Tag # 1A09.1 Medication Delivery - PRN Medication	Scope and Severity Rating: E	Scope and Severity: D
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 4 of 9 Individuals. Individual #2 October 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Tylenol 400mg (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Tylenol 400mg – PRN – 10/30 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Tylenol 400mg – PRN – 10/30 (given 1 time) Individual #8 August 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Advil (PRN) • Ibuprofen (PRN) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Advil – PRN – 08/10, 11 & 12 (given 1 time) • Ibuprofen - PRN - 08/30 (given 1 time) Medication Administration Records did not contain the strength of the medication which is to be	**New & Repeat Findings:** Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 1 of 7 Individuals. Individual #8 April 2011 Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 500mg (PRN) • Ibuprofen 200mg (PRN) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 500mg (PRN) • Ibuprofen 200mg (PRN) Medication Administration Record document did not contain a signature or initials used to document administered or assisted delivery of each dose for the following medications: • Acetaminophen 500mg – PRN - 4/1, 4, 5, 7, 9 & 13 (given 1 time) • Ibuprofen 200mg – PRN – 4/29 (given 1 time) Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following: • Acetaminophen 500mg (PRN) • Ibuprofen 200mg (PRN) Medication Administration Record did not contain all information as required by the Board of Pharmacy.

(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. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued	given: • Advil (PRN) • Ibuprofen (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Advil (PRN) • Ibuprofen (PRN) September 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Advil (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Advil – PRN – 09/29 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Advil – PRN – 10/07, 09, 15 & 23 (given 1 time) Medication Administration Records did not contain the strength of the medication which is to be given: • Advil (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Advil (PRN) October 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:	Medication was written out completely for one day and quotes were used to indicate medication was given on subsequent days: • Acetaminophen 500mg – PRN – 4/2, 3, 4, 5, 7, 9 & 13 (given 1 time) May 2011 Medication Administration Records did not contain the route of administration for the following medications: • Amitriptyline 25mg (PRN) • Acetaminophen 500mg (PRN) • Diphenhydramine 25mg (PRN) • Loratadine 10mg (PRN) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 500mg (PRN) • Amitriptyline 25mg (PRN) • Acetaminophen 500mg (PRN) • Diphenhydramine 25mg (PRN) • Loratadine 10mg (PRN) Medication Administration Record document did not contain a signature or initials used to document administered or assisted delivery of each dose for the following medications: • Amitriptyline 25mg – PRN – 5/2 (given 1 time) Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following: • Acetaminophen 500mg (PRN) • Amitriptyline 25mg (PRN)

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.	• Ibuprofen 400mg (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 400mg – PRN – 10/07, 09, 15 & 23 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Ibuprofen 400mg – PRN – 10/07, 09, 15 & 23 (given 1 time) Individual #9 October 2010 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Lortab 500mg (PRN) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Lortab 500mg (PRN) No Signs/Symptoms were noted on the Medication Administration Record for the following PRN medication: • Lortab 500mg – PRN – 10/21, 22 & 23 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Lortab 500mg – PRN – 10/21, 22 & 23 (given 1 time) Individual #10 September 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour	• Acetaminophen 500mg (PRN) • Diphenhydramine 25mg (PRN) • Loratadine 10mg (PRN) June2011 Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Loratadine 10mg (PRN) • Nupercainal (PRN) Medication Administration Records did not contain the strength of the medication which is to be given: • Albuterol (PRN) • Nupercainal (PRN) No evidence of documented Signs/Symptoms were found for the following PRN medication: • Albuterol – PRN – Month 6/8 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Albuterol – PRN – 6/8 & 9 (given 1 time) • Amitriptyline 25mg – PRN – 6/13 (given 1 time) • Nupercainal – PRN – 6/20 (given 1 time) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Albuterol (PRN) • Amitriptyline 25mg (PRN) • Nupercainal (PRN)

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.	period: • Tylenol Extra Strength 500mg (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Tylenol Extra Strength 500mg (PRN) October 2010 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Acetaminophen 325mg (PRN) Medication Administration Records did not contain the route of administration for the following medications: • Acetaminophen 325mg (PRN)	Medication Administration Records did not contain the route of administration for the following medications: • Albuterol (PRN) • Amitriptyline 25mg (PRN) • Nupercainal (PRN) Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following: • Amitriptyline 25mg (PRN) • Nupercainal (PRN) Medication Administration Record document did not contain a signature or initials used to document administered or assisted delivery of each dose for the following medications: • Albuterol – PRN – 6/8 & 9 (given 1 time) • Amitriptyline 25mg – PRN – 6/13 (given1 time) • Nupercainal – PRN – 6/20 (given 1 time) Medication Administration Record did not contain all information as required by the Board of Pharmacy. Medication was written out completely for one day and quotes were used to indicate medication was given on subsequent days: • Albuterol – PRN – 6/9 (given 1 time)

(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 # 1A20 DSP Training Documents	Scope and Severity Rating: E	Scope and Severity: D
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 24 of 43 Direct Service Professionals. Review of Direct Service Professional training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #48, 54, 55, 60, 65, 68 & 77) • Foundations for Health & Wellness (Formerly Basic Orientation & Health Information) (DSP #41, 57, 60, 68 & 80) • Person-Centered Planning (1-Day) (DSP #48, 55, 68 & 77) • First Aid (DSP #43, 48, 56 & 71) • CPR (DSP #43, 48, 52, 56, 63, 69 & 70) • Assisting With Medication Delivery (DSP #46, 49, 59, 63, 64, 71, 72 & 73) • Rights & Advocacy (DSP #77) • Level 1 Health (DSP #75 & 77) • Participatory Communication & Choice Making (DSP #75)	**New & Repeat Findings:** Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 5 of 55 Direct Service Professionals. Review of Direct Service Professional training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #87 & 110) • Foundations for Health & Wellness (Formerly Basic Orientation & Health Information) (DSP #87 & 110) • Person-Centered Planning (1-Day) (DSP #95) • Assisting With Medication Delivery (DSP #64 & 94)

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 # 6L14 Residential Case File	Scope and Severity Rating: E	Scope and Severity: E
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 5 of 8 Individuals receiving Family Living Services. The following was not found, incomplete and/or not current: • Positive Behavioral Crisis Plan (#2) • Speech Therapy Plan (#2) • Occupational Therapy Plan (#10) • **Health Care Plans** ° GERD (#1 & 9) ° Falls (#1) ° Oxygen (#9) ° Sleep Apnea (#9) • **Crisis Plan** ° Cardiac Condition (#2) ° Constipation (#1) ° Dysphasia (#1) ° Respiratory Distress (#1) ° Falls (#1) ° GERD (#1) ° Gastrointestinal (#2 & 9) ° Sleep Apnea (#9) ° Oxygen (#9) • **Data Collection/Data Tracking:** ° Individual #1 - None found for November 2010 ° Individual #2 - None found for November 2010 ° Individual #4 - None found for November 2010 ° Individual #9 - None found for November 2010	**New & Repeat Findings:** Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 2 of 7 Individuals receiving Family Living Services. The following was not found, incomplete and/or not current: • Annual ISP (#1) • Positive Behavioral Crisis Plan (#2) • **Crisis Plan** ° GERD (#1) ° Cardiac Condition (#2) ° Gastrointestinal (#2) • **Data Collection/Data Tracking:** ° Individual #1 - None found for August 1 – 11, 2011 ° Individual #2 - None found for August 1 – 10, 2011

a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings…	◦ Individual #10 - None found for November 2010 • **Progress Notes written by DSP and/or Nurses regarding Health Status:** ◦ Individual #1 - None found for November 2010 • **Health Care Providers Written Orders** (#1)	

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: F	Scope and Severity: E
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services** (1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has: (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.	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 8 of 8 Family Living residences. The following items were not found, not functioning or incomplete: **Family Living Requirements:** • General-purpose first aid kit (#2 & 5) • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#1, 2, 4, 5, 6, 8, 9 & 10) • 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 (#1, 4, 6, 9 & 10) • 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 (#1, 2, 4, 5, 6, 8, 9 & 10)	**Repeat Findings:** Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 2 of 6 Family Living residences. The following items were not found, not functioning or incomplete: **Family Living Requirements:** • 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 (#1) • 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)

Tag # 6L27 FL Reimbursement	Scope and Severity Rating: C	Scope and Severity: B
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES**	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 9 of 9 individuals. Individual #1 August 2010 • The Agency billed 6 units of Family Living Services from 08/01/2010 through 08/06/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 8 units of Family Living Services from 08/07/2010 through 08/14/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 17 units of Family Living Services from 08/15/2010 through 08/31/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. September 2010 • The Agency billed 30 units of Family Living Services from 09/01/2010 through 09/30/2010. Documentation on these dates did not contain	**New & Repeat Findings:** 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 7 individuals. Individual #8 April 2011 • The Agency billed 14 units of Family Living from 04/01/2011 through 04/14/2011. Documentation received accounted for 13 units. No documentation was found for Family Living on 4/2/2011. Note found indicated individual was with Subcare. May 2011 • The Agency billed 8 units of Family Living from 05/24/2011 through 05/31/2011. Documentation received indicated that Subcare services were provided, no documentation was found for Family Living on those dates. June 2011 • The Agency billed 14 units of Family Living from 06/01/2011 through 06/14/2011. Documentation received indicated that Subcare services were provided, no documentation was found for Family Living on 6/1, 2 & 3. Individual #10 April 2011 • The Agency billed 14 units of Family Living from 04/01/2011 through 04/14/2011. Documentation received accounted for 11 units. No documentation was found for Family Living on 4/2, 3 & 4. Note found indicated individual was with Subcare. June 2011 • The Agency billed 16 units of Family Living from 06/15/2011 through 06/30/2011. Documentation received accounted for 15 units. No documentation

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,	the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. October 2010 • The Agency billed 14 units of Family Living Services from 10/01/2010 through 10/14/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 17 units of Family Living Services from 10/15/2010 through 10/31/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. Individual #2 August 2010 • The Agency billed 14 units of Family Living Services from 08/01/2010 through 08/14/2010. Documentation on these dates did not contain start and end time to justify billing. • The Agency billed 17 units of Family Living Services from 08/15/2010 through 08/31/2010. Documentation on these dates did not contain start and end time to justify billing. September 2010 • The Agency billed 30 units of Family Living	for Family Living was found for 4/15. Note found indicated individual was with Subcare.

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.	Services from 09/01/2010 through 09/30/2010. Documentation on these dates did not contain start and end time to justify billing. October 2010 • The Agency billed 14 units of Family Living Services from 10/01/2010 through 10/14/2010. Documentation on these dates did not contain start and end time to justify billing. • The Agency billed 2 units of Family Living Services from 10/15/2010 through 10/16/2010. Documentation on these dates did not contain start and end time to justify billing. Individual #3 August 2010 • The Agency billed a total of 14 units of Family Living Services on 08/01/2010 through 08/14/2010. Documentation did not contain a description of what occurred during the encounter or service interval on 8/1 & 2 to justify billing. • The Agency billed 14 units of Family Living from 08/01/2010 through 08/14/2010. Review of documentation indicated services were provided concurrently with a Hospital Admission on 08/03/2010 through 08/14/2010. • The Agency billed 16 units of Family Living Services from 08/16/2010 through 08/30/2010. Documentation on these dates did not contain the following: ° a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ° A start and end time to justify billing. September 2010 • The Agency billed 30 units of Family Living	

	Services from 09/01/2010 through 09/30/2010. Documentation on these dates did not contain start and end time to justify billing. October 2010 • The Agency billed 14 units of Family Living Services from 10/01/2010 through 10/14/2010. Documentation on these dates did not contain start and end time to justify billing. • The Agency billed 17 units of Family Living Services from 10/15/2010 through 10/31/2010. Documentation on these dates did not contain start and end time to justify billing. Individual #4 August 2010 • The Agency billed 14 units of Family Living Services from 08/01/2010 through 08/14/2010. Documentation on 8/7, 10 & 14 did not contain the following: ° a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ° A start and end time to justify billing. • The Agency billed a total of 14 units of Family Living Services on 8/1/2010 through 8/14/2010. Documentation did not contain a description of what occurred during the encounter or service interval on 8/1, 2, 3, 4, 5, 6, 8, 9, 11, 12 & 13 to justify billing. Note stated, “Normal Routine.” • The Agency billed 17 units of Family Living Services from 08/15/2010 through 08/30/2010. Documentation on 8/16, 18, 21 & 29 did not contain the following: ° a signature/authenticated name of the staff providing the service to justify billing for each unit billed.	

	◦ A start and end time to justify billing. • The Agency billed a total of 17 units of Family Living Services on 08/15/2010 through 08/30/2010. Documentation did not contain a description of what occurred during the encounter or service interval on 8/15, 17, 19, 20, 22, 23, 24, 25, 26, 27, 28 & 30 to justify billing. Note stated, "Normal Routine." September 2010 • The Agency billed 30 units of Family Living Services from 09/01/2010 through 09/30/2010. Documentation on 9/1, 3, 4, 5, 6, 8, 9, 10, 11, 13, 18, 20, 22, 23, 24, 25, 26, 27, 28, 29 & 30 did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed a total of 17 units of Family Living Services on 09/01/2010 through 09/30/2010. Documentation did not contain a description of what occurred during the encounter or service interval on 9/2, 7, 12, 14, 15, 16, 17, 19 & 21 to justify billing. Note stated, "Normal Routine." October 2010 • The Agency billed 14 units of Family Living Services from 10/01/2010 through 10/14/2010. Documentation on 10/03, 09 & 10 did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed a total of 14 units of Family	

	Living Services on 10/15/2010 through 10/31/2010. Documentation did not contain a description of what occurred during the encounter or service interval on 10/01, 02, 04, 05, 06, 07, 08, 11, 12, 13 & 14 to justify billing. Note stated, "Normal Routine." • The Agency billed 17 units of Family Living Services from 10/15/2010 through 10/31/2010. Documentation on 10/18, 20, 22, 23, 24, 25, 26, 27, 28, 29 & 30 did not contain the following: ° a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ° A start and end time to justify billing. • The Agency billed a total of 17 units of Family Living Services on 10/15/2010 through 10/31/2010. Documentation did not contain a description of what occurred during the encounter or service interval on 10/15, 16, 17, 19, 21 & 31 to justify billing. Note stated, "Normal Routine." Individual #5 August 2010 • The Agency billed 14 units of Family Living Services from 08/01/2010 through 08/14/2010. Documentation on these dates did not contain the following: ° a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ° A start and end time to justify billing. • The Agency billed 17 units of Family Living Services from 08/15/2010 through 08/31/2010. Documentation on these dates did not contain the following: ° a signature/authenticated name of the staff	

	providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. September 2010 • The Agency billed 30 units of Family Living Services from 09/01/2010 through 09/30/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. October 2010 • The Agency billed 14 units of Family Living Services from 10/01/2010 through 10/14/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 17 units of Family Living Services from 10/15/2010 through 10/31/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. Individual #6 October 2010 • The Agency billed 14 units of Family Living from 10/01/2010 through 10/14/2010. Review of documentation indicated services were provided	

	concurrently with Sub Care Services on 10/13 &14. • The Agency billed 17 units of Family Living from 10/15/2010 through 10/31/2010. Review of documentation indicated services were provided concurrently with Sub Care Services on 10/15, 16, 17, 18 & 19. Individual #8 August 2010 • The Agency billed 17 units of Family Living from 08/15/2010 through 08/31/2010. No documentation found to justify billing on 08/21/2010. September 2010 • The Agency billed 30 units of Family Living Services from 09/01/2010 through 09/30/2010. Documentation did not contain start and end time on 09/01, 02, 03, 04, 05, 06, 07, 08, 09, 14, 15, 16, 17, 18, 19, 20, 21 & 22 to justify billing. • The Agency billed 30 units of Family Living from 09/01/2010 through 09/30/2010. No documentation found to justify billing on 09/23, 24, 27, 28, 29 & 30. • The Agency billed a total of 30 units of Family Living Services on 09/01/2010 through 09/30/2010. Documentation did not contain a description of what occurred during the encounter or service interval on 09/13 to justify billing. • The Agency billed 30 units of Family Living from 09/01/2010 through 09/30/2010. Review of documentation indicated services were provided concurrently with Sub Care Services on 09/10, 11, 12, 25 & 26. October 2010	

	• The Agency billed 14 units of Family Living Services from 10/01/2010 through 10/14/2010. Documentation on these dates did not contain start and end time to justify billing. • The Agency billed 17 units of Family Living Services from 10/15/2010 through 10/30/2010. Documentation did not contain start and end time on 10/15. 16, 17, 18, 19, 20, 222, 23, 24, 25, 26, 27, 28, 29, 30 & 31 to justify billing. • The Agency billed 17 units of Family Living from 10/15/2010 through 10/31/2010. No documentation found to justify billing on 10/21/2010. Individual #9 August 2010 • The Agency billed 14 units of Family Living Services from 08/01/2010 through 08/14/2010. Documentation on these dates did not contain start and end time to justify billing. • The Agency billed 1 unit of Family Living Services on 08/15/2010. Documentation did not contain start and end time to justify billing. • The Agency billed 8 units of Family Living Services from 08/17/2010 through 08/24/2010. Documentation on these dates did not contain start and end time to justify billing. • The Agency billed 6 units of Family Living Services from 08/26/2010 through 08/31/2010. Documentation on these dates did not contain start and end time to justify billing. September 2010 • The Agency billed 13 units of Family Living Services from 09/01/2010 through 09/13/2010. Documentation on these dates did not contain start and end time to justify billing.	

	• The Agency billed 15 units of Family Living Services from 09/17/2010 through 09/30/2010. Documentation on these dates did not contain start and end time to justify billing. October 2010 • The Agency billed 14 units of Family Living Services from 10/01/2010 through 10/14/2010. Documentation on these dates did not contain start and end time to justify billing. • The Agency billed 1 unit of Family Living Services on 10/15/2010. Documentation did not contain start and end time to justify billing. • The Agency billed 2 units of Family Living Services from 10/17/2010 through 10/18/2010. Documentation on these dates did not contain start and end time to justify billing. • The Agency billed 1 unit of Family Living Services on 10/21/2010. Documentation did not contain start and end time to justify billing. • The Agency billed 9 units of Family Living Services from 10/23/2010 through 10/31/2010. Documentation on these dates did not contain start and end time to justify billing. Individual #10 August 2010 • The Agency billed 9 units of Family Living Services from 08/01/2010 through 08/09/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing.	

	• The Agency billed 5 units of Family Living Services from 08/10/2010 through 08/14/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 17 units of Family Living Services from 08/15/2010 through 08/31/2010. Documentation on these dates on 08/15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 & 31 did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 17 units of Family Living from 08/15/2010 through 08/31/2010. Review of documentation indicated services were provided concurrently with Sub Care Services on 08/17. September 2010 • The Agency billed 30 units of Family Living Services from 09/01/2010 through 09/30/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. October 2010 • The Agency billed 14 units of Family Living Services from 10/01/2010 through 10/14/2010. Documentation on 10/01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 12, 13 & 14 did not contain the	

	following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing. • The Agency billed 14 units of Family Living from 10/01/2010 through 10/14/2010. Review of documentation indicated services were provided concurrently with Sub Care Services on 10/11. • The Agency billed 17 units of Family Living Services from 10/15/2010 through 10/31/2010. Documentation on these dates did not contain the following: ◦ a signature/authenticated name of the staff providing the service to justify billing for each unit billed. ◦ A start and end time to justify billing.	

Standard of Care	November 30 – December 3, 2010 Scope and Severity Ratings	August 9 – 11, 2011 Verification Survey – Plan of Correction Process Verification Results
Tag # 1A08 Agency Case File	Scope and Severity Rating: B	Completed
Tag # 1A09.2 Medication Delivery - PRN Nurse Approval	Scope and Severity Rating: F	Completed
Tag # 1A11 (CoP) Transportation P&P	Scope and Severity Rating: F	Completed
Tag # 1A11.1 (CoP) Transportation Training	Scope and Severity Rating: D	Completed
Tag # 1A15.1 Nurse Availability	Scope and Severity Rating: D	Completed
Tag # 1A15.2 & 5I09 - Healthcare Documentation	Scope and Severity Rating: D	Completed
Tag # 1A22 Staff Competence	Scope and Severity Rating: D	Completed
Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D	Completed
Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E	Completed
Tag # 1A28.1 (CoP) Incident Mgt. System - Personnel Training	Scope and Severity Rating: E	Completed
Tag # 1A28.2 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope and Severity Rating: E	Completed
Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: E	Completed
Tag # 1A36 SC Training	Scope and Severity Rating: B	Completed
Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D	Completed
Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: B	Completed
Tag # 5I36 CA Reimbursement	Scope and Severity Rating: B	Completed

Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: E	Completed
Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E	Completed
Tag # 6L25.1 (CoP) Residential Reqts. (Physical Environment - Supported Living & Family Living)	Scope and Severity Rating: D	Completed (Individual originally cited is no longer receiving services from the agency).